

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04500
462

CERTIFICATE OF DEATH

Reg. Dist. No. 7

1. PLACE OF DEATH:

County Allegany

City or town Flintstone

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 32 Years

Hospital, institution, or street address where death occurred:

Rural

How long in hospital or institution?

3. (a) FULL NAME

Sarah Jane Alt

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

White

Married

6. (b) Name of husband or wife

Enoch Alt

5. (c) If alive, give age 82 years

7. Birth date of deceased (mo. day, yr.)

January 17 1872

8. AGE:

Years

Months

Days

If less than one day

76

3

17

hrs.

min.

9. Birthplace Landis, Penelton Co., W. Va.

(Town, county, and state)

10. Usual occupation

House

"

11. Industry or business

Isaac Judy

12. Name

West Virginia

13. Birthplace

Sena Mallow

14. Maiden name

West Virginia

15. Birthplace

Mrs. Dayton Dolly

16. Informant

Flintstone W. Va., Md.

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 5/7/48

(month) (day) (year)

Cemetery or crematory

Glendale Cemetery

Location

Flintstone, Md.

18. Funeral director

William H. Kight

Address

Cumberland, Md.

19. Date rec'd by registrar

19.....

Miss L. Beeler

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Allegany

City or town Flintstone

(If outside city or town limits, write RURAL and give nearest town)

Street No.

Rural

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 4

1948 at 5:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 15 1948 to May 4 1948

and that I last saw her alive on May 4 1948

Immediate cause of death

Carcinoma of Colon

DURATION

Due to

Due to

Other conditions Metastasis to lungs.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or Town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Benedict Skitarelic M.D.

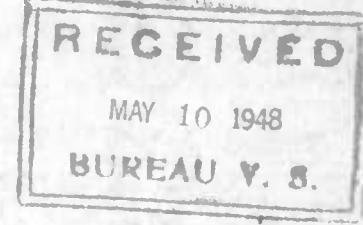
M. D. or other

R² Cumberland, Md. Date signed 5/15/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I MARGIN RESERVED FOR BINDING

VS A15 9-45-15M



M
 PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct size is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04501

CERTIFICATE OF DEATH

Reg. Dist. No. 10

1. PLACE OF DEATH:

County Allegany

City or town Mt. Savage Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Mrs. Daniel (Ruth Miller) Arnold

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Female White Married

6.(b) Name of husband or wife Daniel Arnold

6.(c) If alive, give age 66 years

7. Birth date of deceased (mo. day. yr.)

Feb. 27- 1883

8. AGE: Years Months Days If less than one day
65 2 15 hrs. min.9. Birthplace Cumberland Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Home

12. Name Louis Miller

13. Birthplace Cumberland Md.

14. Maiden name Elizabeth Faupel

15. Birthplace West Virginia

16. Informant Daniel Arnold,

Address Mt. Savage, Md.

17. Burial Date thereof May 17, 1948
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory St. Georges Cemetery,
Location Mt. Savage, Md.

18. Funeral director J. R. Durst,

Address Frostburg, Md.

19. May 17 1948 Venessa M. Terrell
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md.

County

Allegany

City or town Mt. Savage

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

about

20. DATE OF DEATH May 14 1948 at 3 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw her Dead May 14 1948

Immediate cause of death Cerebral hemorrhage due to
a rupture of a cerebral vessel once
During while in a convulsion

Due to

Other conditions Had a brain tumor removed in
right temporal region 4 yrs. ago.
(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

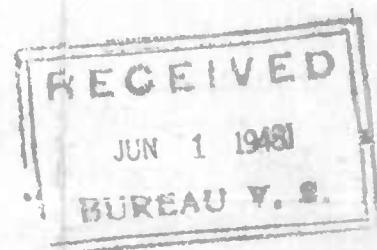
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Deputy Medical Examiner Allegany Co.

23. SIGNATURE H. V. Deming M.D. H. V. Deming M.D. M. D. or

Address Cumberland Md. Date signed 5.15-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH Dr Paul R. Wilson
2411 N. Charles St., Baltimore 131a 04502
CERTIFICATE OF DEATH Reg. Dist. No.

1. PLACE OF DEATH:

County Allegany
City or town Luke
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 48 years
Hospital, institution, or street address where death occurred: Fairview Street
How long in hospital or institution?.....

3. (a) FULL NAME

ARVID HARMON BENSON

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male White

Married

6.(b) Name of husband or wife

Bonnie Brumbaugh Benson

6.(c) If alive, give age

35

years

7. Birth date of deceased (mo. day, yr.)

December 28, 1899

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Luke, Allegany, Maryland
(Town, county, and state)

Laborer

10. Usual occupation

Paper Mill

MOTHER FATHER

12. Name Andrew Benson

13. Birthplace Sweden

14. Maiden name Bessie Johnston

15. Birthplace Sweden

16. Informant Mrs. Bonnie B. Benson

Address Luke, Maryland

17. Burial

(Burial, cremation, or removal. Which?) Date thereof May 28, 1948

(month) (day) (year)

Cemetery or crematory Philo's Cemetery

Location Westernport, Maryland

18. Funeral director Ellsworth S. Boal

Address Westernport, Maryland

19. May 28 1948
(Date read by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Luke

(If outside city or town limits, write RURAL and give nearest town)

Street No. Fairview Street

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 25

19 48 21 9:30 a.m.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Feb 26 1948 May 26 1948

and that I last saw h. m. alive on May 26 1948

Immediate cause of death Hemiplegia and
other paralysis of unspecified
origin.

Due to High Blood pressure (idiopathic)

Due to chronic Nephritis

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

None

Date of op.

Autopsy results.....

None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

None

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

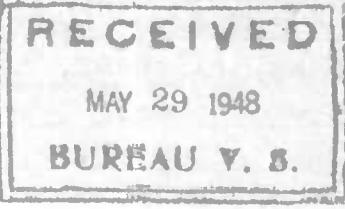
23. SIGNATURE.....

Paul R. Wilson, M.D.

M. D. or other

Piedmont, W. Va.

Date signed May 27, 1948



Within corporate limits
Dr. R. W.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04503

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
 County ALLEGANY COUNTY
 City or town CUMBERLAND, MARYLAND

(If outside city or town limits, write RURAL and give nearest town)
 154 DAYS

How long in above place of death?

Hospital, institution, or street address where death occurred:
 MEMORIAL HOSPITAL

How long in hospital or institution? 154 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 MARYLAND

State WESTERNPORT County

City or town (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war.

3. (b) Social Security Number

Note

3. (a) FULL NAME
 PAUL BISHOP

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

6.(b) Name of husband or wife.

7. Birth date of deceased (mo., day, yr.) December 16, 1928

8. AGE: Years	Months	Days	If less than one day
19	5	13	hrs. min.

9. Birthplace WESTERNPORT, ALLEG. MARYLAND
 (Town, county, and state)

10. Usual occupation NONE

11. Industry or business JOHN L. BISHOP

MOTHER FATHER 12. Name MARYLAND

13. Birthplace HAZEL, BISHOP

14. Maiden name RYLAND

15. Birthplace MA

16. Informant Hospital Record

Address

17. Burial Date thereof June 1, 1948

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Bloomington Cem.

Location Bloomington, Md

18. Funeral director Edward S. Boal

Address Westernport, Md.

June 1, 1948 W.H. Frank, M.D.

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 29 1948

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 15 1948 to May 29 1948

and that I last saw him alive on May 29 1948

Immediate cause of death Myocardial Failure

DURATION

Due to Rheumatic Fever 5 yrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

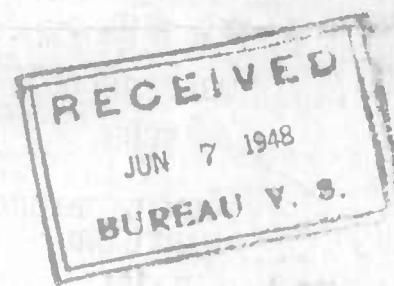
Means of injury Injured at work?

23. SIGNATURE

M. D. or other

Date signed

Address



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04564

1318

9

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH:

County..... Allegany

City or town..... Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 mos

Hospital, institution, or street address where death occurred: Mount Hospital

How long in hospital or institution? 6 weeks

3. (a) FULL NAME

Charles Stanley Blubaugh

(BLUBAUGH)

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male white Single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age..... years

June 12 - 1864

8. AGE: Years Months Days If less than one day

83 11 17 hrs. min.

9. Birthplace..... Allegany

(Town, County, and state)

10. Usual occupation..... Laborer

11. Industry or business..... G. & B. Co.

12. Name..... Peter Blubaugh

13. Birthplace..... Allegany

14. Maiden name..... Elizabeth Sharff

15. Birthplace..... Allegany

16. Informant..... Mrs. Lee Blubaugh

Address..... P. O. Box Frostburg, Md

17. Burial..... 5-31-1948

(Date thereof) (month) (day) (year)

(Burial, cremation, or removal. Which?) Cemetery

Cemetery..... Allegany Cemetery

Location..... Frostburg, Md

18. Funeral director..... Jacob Waters

Address..... Frostburg, Md

19. Date rec'd by registrar..... June 3, 1948

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md.

County..... Allegany

City or town..... Frostburg

(If outside city or town limits, write RURAL and give nearest town)

Street No..... Park Ave.

(If rural, give LOCATION)

2. (a) If veteran, name war.....

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 29 1948 at 130 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 1 1948 to May 29 1948

and that I last saw him alive on May 29 1948

Immediate cause of death..... Chronic myocarditis

DURATION

several

Cause of death..... The Respiratory

years

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE..... M. D. or other

Address..... Frostburg, Md Date signed..... June 21 1948

Registrar

RECEIVED

JUN 7 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04565

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Monroe Hospital

How long in hospital or institution?

Life

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male

White

Single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

May 23, 1948

years

8. AGE:

Years

Months

Days

It less than one day

9 hrs.

46 min.

9. Birthplace

Frostburg, Allegany, Md.

(Town, county, and state)

10. Usual occupation.

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. Date rec'd by registrar

19. Date rec'd by registrar

Date thereof May 24, 1948
(month) (day) (year)



~~Within corporate limits~~
 PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In case of age is especially important. Physicians: please write the causes of death clearly and legibly.

DR. W. F. WILLIAMS
 Evidence for change of age
 shown on:

AM No. G 116 JUL 9 1948 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04506

39C

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution?

7 HOURS

3. (a) FULL NAME

MR. DEWEY ARTHUR BOWEN

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

MALE

WHITE

MARRIED

6. (b) Name of husband or wife MAMIE ELIZABETH DELAWDER

6. (c) If alive, give age 31 years

7. Birth date of deceased (mo. day. yr.)

JULY 12, 1906

8. AGE:

Years 41

Months 42

Days 10

If less than one day 3

hrs. min.

9. Birthplace

Stampshire County, West Virginia (Town, county, and state)

10. Usual occupation BALTIMORE & OHIO RAILROAD

11. Industry or business

laborer

MOTHER FATHER

12. Name MR. WILLIAM ARTHUR BOWEN

MOTHER FATHER

13. Birthplace WEST VIRGINIA

MOTHER FATHER

14. Maiden name ANNIE MAY WRIGHT

MOTHER FATHER

15. Birthplace MARYLAND

16. Informant

MEMORIAL HOSPITAL

Address

MEMORIAL AVE., CUMBERLAND, MD.

Burial

(Burial, cremation, or removal. Which?)

Date thereof May 18 1948
 (month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. Date rec'd by registrar

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State W. VA.

County HAMPSHIRE, W. VA.

City or town POINTS, W. VA.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

232-26-0798

MEDICAL CERTIFICATION

20. DATE OF DEATH

MAY 15,

19 48 at 3:10 A.M.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from

5-14-48 to 5-15-48

and that I last saw him alive on 5-15-48

Immediate cause of death

Rocky Mountain

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

None

Date of op. None

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. F. Williams

M.D. or other

Address

Date signed 5/15/48

RECEIVED

MAY 18 1948

BUREAU V. S.

Within corporate limits

M
The correct age

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04567

CERTIFICATE OF DEATH

Reg. Dist. No. 4

93d

1. PLACE OF DEATH: Allegany
 County.....
 City or town..... Cumberland
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....
 Hospital, institution, or street address where death occurred: 837 Gephart Drive

How long in hospital or institution?.....

3. (a) FULL NAME
 ALICE M. CADDEN

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Allegany
 City or town..... Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 837 Gephart Drive
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number
 None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife..... James H. Cadden

7. Birth date of deceased (mo., day, yr.) March 7, 1868
 6.(c) If alive, give age years

8. AGE: Years Months Days It less than one day
 80 2 20 hrs. min.

9. Birthplace..... Bloomington, Md.
 (Town, county, and state)

10. Usual occupation..... Housewife

11. Industry or business.....

FATHER	12. Name..... Andrew Mullen
	13. Birthplace..... Maryland

MOTHER	14. Maiden name..... Clementine Pattison
	15. Birthplace..... Maryland

16. Informant..... Miss Eleanor Cadden
 Address 837 Gephart Drive, Cumberland,

17. Burial Date thereof..... May 29, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory..... S. S. Peter & Paul

Location..... Cumberland, Md.

18. Funeral director..... H. Wayne George
 Address..... Cumberland, Md.

19. May 29, 1948 L. H. Tracy, M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH..... May 27, 1948 at 4:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 26/48 10 A.M. to May 27 1948

and that I last saw her alive on May 26 1948

Immediate cause of death..... Cardiac decompensation DURATION

1.8 hrs

Due to..... Obstruction to respiration 7 yrs

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... J. H. Tracy, M.D. M. D. or other

Address..... D. Green St. Date signed May 29/48

RECEIVED
JUN 2 1948
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

122

04508

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: Allegany
 County Cumberland
 City or town (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?
 Hospital, Institution, or street address where death occurred:
 Allegany Hospital

How long in hospital or institution? 54 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State Maryland County Allegany
 City or town Cumberland
 Street No. 728 Hill Top Drive
 (If outside city or town limits, write RURAL and give nearest town)
 (If rural, give LOCATION)

2.(a) Is veteran, name war.....

3. (a) FULL NAME Alice Carney

3. (b) Social Security Number None

4. Sex Female	5. Color or race White	6.(a) Single, married, widowed, or divorced Married
---------------	------------------------	---

6.(b) Name of husband or wife J. Joseph Carney Jr.

7. Birth date of deceased (mo., day, yr.) March 12, 1900

8. AGE: Years 48 Months 1 Days 24 If less than one day hrs. min.

9. Birthplace Cumberland, Allegany, Maryland
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

MOTHER FATHER 12. Name Frank J. Graebenstein
 13. Birthplace Cumberland, Md.

14. Maiden name Anna Miltenberger
 15. Birthplace Ortana, Penna.

16. Informant Mr. J. Joseph Carney Jr.
 Address 728 Hilltop Drive Cumberland, Md

Burial 17. Date thereof May 10, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St Marys' Cem.
 Location Cumberland, Md.

18. Funeral director Charles L. George
 Address Cumberland, Md.

May 8, 1948 - W.R. Dantz, M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 6, 48 at 7:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-12-48 to 5-5-48 and that I last saw her alive on 5-5-48.

Immediate cause of death Mesenteric Thrombosis & Volvulus: Intestinal obstruction.

DURATION 12 hrs

Due to:

Due to:

Other conditions Toxemia, fecal fistula

(Include pregnancy within 3 months of death)

Major findings of operations Appendectomy & small intestine resection of stricture Date of op. 3-12-48

Autopsy results Liver nodule

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

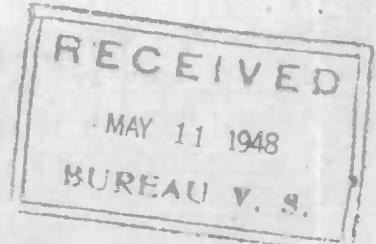
Moore of injury Injured at work?

23. SIGNATURE O. S. G. Carney

M. D. or other

Date signed 5-8-48

Address



Evidence for correction of MARYLAND STATE DEPARTMENT OF HEALTH
questions 7 & 8 shown on:

2411 N. Charles St., Baltimore

61

04599

8

HLM No. G 116 JUN - 2 1948 CERTIFICATE OF DEATH

Reg. Diat. No.

1. PLACE OF DEATH:

County

Allegany - Route 1 - Frostburg

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Mary Cesnick

4. Sex

Female

White

5. Color or race

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Joseph Cesnick

7. Birth date of deceased (mo., day, yr.)

Jan 9, 1878

6. (c) If alive, give age 7 years

8. AGE:

Years

Months

Days

If less than one day

70

3

28

hrs.

min.

9. Birthplace

Budapest

(Town, county, and state)

10. Usual occupation

Housework

11. Industry or business

Own home

Father

12. Name

John Cesnick

13. Birthplace

Hungary

14. Maiden name

Katherine Cesnick

15. Birthplace

Hungary

16. Informant

John Cesnick

Address

Midland, Md

17. Burial

Burial

(Burial, cremation, or removal. Which?)

Date thereof May 10, 1948

(month) (day) (year)

Cemetery or crematory

Belvedere Cemetery

Location

Midland, Md

18. Funeral director

Mr. Eichhorn

Address

Loracorrig, Md

19. Date rec'd by registrar

May 10, 1948

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Rural - Island of Frostburg
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 7

19

at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

January 19, 1948, to May 7, 1948,
and that I last saw her alive on May 7, 1948.

Immediate cause of death

C-V-R Disease

Due to

Diabetes Mellitus

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W.C. Galtney, M.D. M.D. or other

Address Frostburg, Md Date signed July 14, 1948



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04510
1316

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County **Allegany**
Cumberland

City or town (If outside city or town limits, write RURAL and give nearest town)

4 years

How long in above place of death?

Hospital, institution, or street address where death occurred:

Allegany Hospital

How long in hospital or institution?

2 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State **Virginia** County **Maryland** Allegany

City or town (If outside city or town limits, write RURAL and give nearest town)

Street No. **19 Washington St.**

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

227-16-8056

3. (a) FULL NAME

John F. Coffman

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife

..... 6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

August 12, 1914

8. AGE:

33

Years

9

Months

17

Days

17

It less than one day

.....

hrs. min.

9. Birthplace

Bell Buckle, Bedford, Tennessee

(Town, county, and state)

10. Usual occupation

Chemist

11. Industry or business

Celanese Corp. of America

MOTHER FATHER

12. Name **W. C. Coffman**13. Birthplace **Bedford Co. Tenn.**

14. Maiden name

Annie May Fletcher

15. Birthplace

Bedford Co. Tenn.

16. Informant

Mr. W. H. Carter

Address

Amherst, Virginia

17. Removal

Date thereof **May 31, 1948**

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Hazel Cemetery

Cemetery or crematory

Bell Buckle, Tennessee

Location

18. Funeral director

William H. Kight

Address

Cumberland, Md.19. **May 31, 1948**

(Date rec'd by registrar)

Registrar

23. SIGNATURE

W. H. Coffman, M.D.

M. D. or other

Address **49 Main St.** Date signed **5/30/48**

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 29, 1948

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dept. 1946 1948 to **May 29, 1948** 1948and that I last saw him alive on **May 29, 1948** 1948

Immediate cause of death

Chronic Endocarditis

Due to

Chronic Tiphilicosis

Due to

Acute Influenza

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

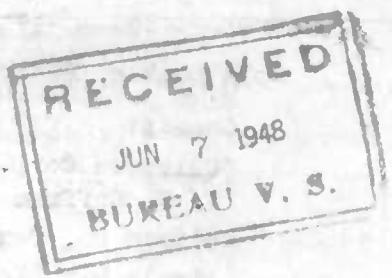
Injured at work?

23. SIGNATURE

W. H. Coffman, M.D.

M. D. or other

Address **49 Main St.** Date signed **5/30/48**



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct date is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d
04501

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

15 days

Hospital, institution, or street address where death occurred:

Memorial Hospital

How long in hospital or institution?.....

15 days

3. (a) FULL NAME

Richard Willard Connor

3. (b) Social Security Number

220-10-8610

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male White Married

6. (b) Name of husband or wife.....

Leonard A. Connor

7. Birth date of deceased (mo., day, yr.)

Mar. 28 - 1889

6. (c) If alive, give age..... years

8. AGE:

Years Months Days If less than one day

59 3 0 hrs. min.

9. Birthplace.....

Eckhardt Alley, Md.

(Town, county, and state)

10. Usual occupation.....

Custodian

11. Industry or business.....

Calais Corp.

12. Name.....

Leonard A. Connor

13. Birthplace.....

Eckhardt, Md.

14. Maiden name.....

Emmeline Davis

15. Birthplace.....

Pittsburgh, Pa.

16. Informant.....

Mrs. P. M. Connor

Address.....

Eckhardt, Md.

17. Burial.....

Date thereof.....

5-30-1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory.....

Eckhardt Cemetery

Location.....

Eckhardt, Md.

18. Funeral director.....

Jacot, Wagner

Address.....

Frederick, Md.

19. Date rec'd by registrar.....

May 29, 1948

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md. County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

MEDICAL CERTIFICATION

2D. DATE OF DEATH

2 May 28 1948 at 6:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 31, 1948, to May 28, 1948,

and that I last saw him alive on May 27, 1948.

Immediate cause of death.....

Chronic Myocarditis 5 mo

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE.....

M. D. or other

Address.....

Date signed

RECEIVED

JUN 3 1948

BUREAU V. S.

M PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

468

045129

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH: Allegany
 County.....
 City or town..... Frostburg
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? all his life
 Hospital, institution, or street address where death occurred:
 28 W. Mechanic St.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State..... Maryland County..... Allegany
 City or town..... Frostburg
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 28 W. Mechanic St.
 (If rural, give LOCATION)

3. (a) FULL NAME
 JOHN G. COOK

3. (b) Social Security Number
 215-10-4495

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Edith R. Cook

7. Birth date of deceased (mo., day, yr.) March 26, 1881
 6. (c) If alive, give age 63 years

8. AGE: Years 67 Months 2 Days 2 If less than one day hrs. min.

9. Birthplace Moscow, Allegany, Maryland
 (Town, county, and state)

10. Usual occupation Mortician

11. Industry or business Funeral home
 MOTHER FATHER Name William H. Cook,

12. Name England

13. Birthplace Janet Morton,

14. Maiden name Scotland

15. Birthplace Dr. Albert Cook,

16. Informant Frostburg, Md.
 Address

17. Burial Allegany Cemetery,
 Date thereof June 1, 1948
 (Burial, cremation, or removal. Which?)

Cemetery or crematory Frostburg, Md.

18. Funeral director J. R. Durst,

Address Frostburg, Md.

19. 6-1 1948 Mrs. Harry V. Roe
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 29 May 1948 at 8 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

18 on. 1947 19. to 29 May 1948 19.

and that I last saw h. m. alive on 27 May 1948 19.

Immediate cause of death

Colitis Stomach
 Hemorrhage Colostomy

DURATION 18 months

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations adenocarcinoma of
 Stomach with metastasis Date of op. Jan 1947

Autopsy results not done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

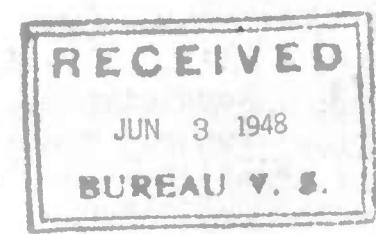
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Mr. Alfred Von Oene

M. D. or other

Address Cumberland, Md. Date signed 30 May 1948



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04513

CERTIFICATE OF DEATH

Reg. Dlat. No. 4

1. PLACE OF DEATH:
 County..... Allegany
 City or town..... Cumberland, Md.
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? _____
 Hospital, Institution, or street address where death occurred:
 Sunbury Ave. _____

How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State..... Md. County..... Allegany
 City or town..... Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... Sunbury Ave.
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME
 Harry Lee Cornelius Sr.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife..... Amanda Hill

7. Birth date of deceased (mo., day, yr.) Nov. 29 1888

8. AGE: Years Months Days If less than one day

59 5 14 hrs. min.

9. Birthplace Pittsburgh, Pa. (Allegheny County)
 (Town, county, and state)

10. Usual occupation Retired Purchasing Agent.

11. Industry or business Celanese Plant

12. Name Edgar F. Cornelius

13. Birthplace Penna.

14. Maiden name Elizabeth Evans

15. Birthplace Penna.

16. Informant Mrs H. L. Cornelius Sr.

Address Sunbury Ave. Cumberland, Md.

17. Burial Date thereof May 15 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Hill Crest Cemetery

Location Cumberland, Md.

18. Funeral director H. Wayne George

Address Cumberland, Md.

19. May 14 1948 Wmte R. Scott, M.D.
 (Date read by registrar) Registrat

3. (b) Social Security Number
 214 07 1539

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13 1948 at 4:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 10 1948 to May 13 1948
 and that I last saw him alive on May 13 1948

Immediate cause of death

Chronic Myocarditis
 Coronary Thrombosis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wmte R. Scott, M.D. or other

Address 49 Green St. Date signed May 14/48

RECEIVED

MAY 18 1948

BUREAU V. S.

Within corporate limits

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04514

94a

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County Allegany

City or town Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
43 Offutt St.

How long in hospital or institution?

3. (a) FULL NAME

John Crabtree

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
male	white	widower

6. (b) Name of husband or wife Tracey Thomas

7. Birth date of deceased (mo., day, yr.) July 26- 1876

8. AGE: Years Months Days It less than one day
71 9 28 hrs. min.

9. Birthplace Old Town Md.
(Town, county, and state)

10. Usual occupation Bartender - Retired

11. Industry or business

MOTHER FATHER
12. Name John Crabtree
13. Birthplace Maryland

14. Maiden name Lydia Maryland
15. Birthplace Maryland

16. Informant (son) Irvin Crabtree

Address 43 Offutt St Cumberland Md.

17. Burial Date thereof May 22 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Cumberland Md.

18. Funeral director Louis Stein Mrs.

Address Cumberland Md.

19. May 21, 1948 W. L. Trautz M.D.
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 43 Offutt St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH May 19 1948 at 10.25 M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19. and that I last saw h. in a Dead May 20 1948

Immediate cause of death Angina Pectoris

DURATION
at once

Due to Coronary sclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Deputy Medical Examiner = Allegany Co.

23. SIGNATURE H.V. Deming M.D. H.V. Deming M.D.

M. D. or

Address Cumberland Md. Date signed 5-20-48



W.F.WILLIAMS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

04515
4

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 HOURS

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution? 7 HOURS

3. (a) FULL NAME

MRS. MINNIE CUSTER

4. Sex

FEMALE

5. Color or race

WHITE

6.(a) Single, married, widowed, or divorced

MARRIED

6.(b) Name of husband or wife Mr. DAVID CUSTER

6.(c) If alive, give age 86 years

7. Birth date of deceased (mo., day, yr.)

MARCH 7, 1866

8. AGE: Years Months Days If less than one day

82 2 14 7 hrs min.

9. Birthplace MARYLAND Sassafras, Garrett Co.

(Town, county, and state)

10. Usual occupation HOUSE WIFE

11. Industry or business Own home

12. Name David Harrison Friend

13. Birthplace Garrett County, Maryland

14. Maiden name May like

15. Birthplace Garrett County, Maryland

16. Informant MEMORIAL HOSPITAL

MEMORIAL AVENUE, CITY

Address Basile

17. Burial Date thereof May 23, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Blooming Tree

Location Friendsville Md

18. Funeral director Emory Goldson

Address Oakland Md

19. Date rec'd by registrar May 22, 1948 W.H. Tracy, M.D.

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND

County GARRETT

City or town FRIENDSVILLE, MD.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH

MAY 21, 1948 at 5:15 A.M.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from

May 20, 1948 to May 21, 1948
and that I last saw her alive on May 20, 1948

Immediate cause of death

Due to Coronary Thrombosis

Generalized Arterio-
Sclerosis.

Injuries of age.

Other conditions

(Include pregnancy within 2 months of death)

Major findings of operations

None

Date of op. None

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

W.F. Williams

M. D. - Other

Cumberland 5/21/48

Address

RECEIVED
MAY 25 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04516

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH:

County Allegany

City or town Cumslerland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 54 years

Hospital, institution, or street address where death occurred: Queen City Hotel

How long in hospital or institution?

3. (a) FULL NAME

Francis Dahl

4. Sex

M

5. Color or race

W

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo. day yr.)

April 6 - 1893

8. AGE: Years

55

Months

1

Days

16

If less than one day

hrs.

min.

9. Birthplace

Carriagenville Md.

(Town, county, and state)

10. Usual occupation

Cook

11. Industry or business

Queen City Hotel

MOTHER FATHER

12. Name William Dahl

13. Birthplace Germany

14. Maiden name Rachel Beals

15. Birthplace Pennsylvania

16. Informant Henry Dahl

Address Queen City Hotel, Cumberland, Md.

17. Burial

Date thereof May 25, 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory St. Peter & Paul's Cemetery

Location Cumberland, Md.

18. Funeral director

John J. Hager

Address Cumberland, Md.

19. Date recd by registrar

19.

May 25 1948 W.R. Frank M.D.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. Queen City Hotel

(If rural, give LOCATION)

2.(a) If veteran, name war World War I

3. (b) Social Security Number

214-05-9377

MEDICAL CERTIFICATION

20. DATE OF DEATH May 22 1948 at 5 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive Dead May 22 1948

Immediate cause of death

Coronary occlusion

Due to coronary sclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

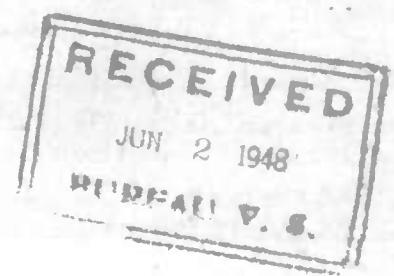
Injured at home, farm, industry, public place (where?)

Means of Injury Deputy Medical Examiner Injured at work Attorney

23. SIGNATURE H.V. Deming M.D. H.V. Deming M.D.

M. D. or

Address Cumberland, Md. Date signed 5-22-48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

157
045179

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County..... Allegany Co.
 City or town..... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, Institution, or street address where death occurred:
Meredith Hospital

How long in hospital or institution? 1 day

3. (a) FULL NAME

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced ✓

6. (b) Name of husband or wife ✓

7. Birth date of deceased (mo., day, yr.) May 1, 1948

6. (c) If alive, give age ✓ years

8. AGE: Years Months Days 11 less than one day

1, hrs. min.

9. Birthplace: Hagerstown, Allegany, Md.

(Town, county, and state)

10. Usual occupation.

11. Industry or business ✓

12. Name: John Theodore Blasius Jr.

13. Birthplace: Hagerstown, Md.

14. Maiden name: Jeanne Frances Flanders

15. Birthplace: Royal Oak, Mich.

16. Informant: Mrs. John T. Blasius

Address: Cresaptown, Md.

17. Burial: Bereal

(Burial, cremation, or removal, where?) Dale thereof 5-3-1948

(month) (day) (year)

Cemetery or crematory: Vale Cemetery

Location: Vale Cemetery, Md. (Hagerstown)

18. Funeral director: John T. Blasius

Address: Cresaptown, Md.

19. Date rec'd by registrar: 5-3-48

19. Date signed: 5-2-48

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Cresaptown

(If outside city or town limits, write RURAL and give nearest town)

Street No.: _____

(If rural, give LOCATION)

2.(a) If veteran, name war: _____

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 2 1948, at 11 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 1, 1948, to May 2, 1948,

and that I last saw him alive on May 2, 1948.

Immediate cause of death: Premature birth 2 1/2 mos.

DURATION: 1 day.

Due to: Premature birth 2 1/2 mos.

Due to: _____

Other conditions: _____

(Include pregnancy within 8 months of death)

Major findings of operations: X Date of op. _____

Autopsy results: _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: _____ Date of: _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

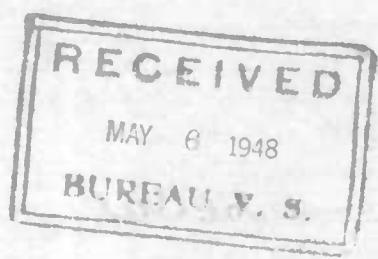
Injured at home, farm, industry, public place (where?) _____

Means of injury: _____ Injured at work? _____

23. SIGNATURE: H.C. Siehl, M.D.

M. D. or other _____ Date signed: 5-2-48

Address: Frostburg, Md.



Within corporate limits

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04518
131a

Reg. Dist. No. 4

CERTIFICATE OF DEATH

1. PLACE OF DEATH: Allegany
 County: Oscarville
 City or town: Oscarville (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 day
 Hospital, Institution, or street address where death occurred: Allegany Hospital
 How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany
 City or town: Oscarville (If outside city or town limits, write RURAL and give nearest town)
 Street No.: 1
 (If rural, give LOCATION) No.

2.(a) If veteran, name war.

3. (a) FULL NAME Sarah Washington Dawson4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Ida W. Fawcett7. Birth date of deceased (mo., day, yr.) Mar. 2, 1864 6. (c) If alive, give age 94 years8. AGE: Years 94 Months 2 Days 26 If less than one day hrs. min.9. Birthplace Dawson, Maryland (Town, county, and state)10. Usual occupation Teacher Retired11. Industry or business Md. Coal Co. of Monaca12. Name James O. Dawson13. Birthplace Dawson, Md.14. Maiden name Anora B. Dawson15. Birthplace Dawson, Md.16. Informant Mrs. SalisburyAddress Goracoming, Md.17. Burial Burial Date thereof May 31, 1948 (month) (day) (year)Cemetery or crematory Oak Hill CemeteryLocation Goracoming, Md.18. Funeral director Mr. S. J. MorrisAddress Goracoming, Md.19. Date rec'd by registrar May 31, 1948 W. H. Frank, M.D.
(Date rec'd by registrar)

Registrar

3. (b) Social Security Number None

MEDICAL CERTIFICATION

20. DATE OF DEATH May 28, 1948 at 10:30 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 27, 1948, to May 28, 1948, and that I last saw him alive on May 27, 1948.Immediate cause of death Cerebral Hemorrhage DURATION 1 dayDue to Cerebral Hemorrhage Right side?Due to Generalized Convulsions -Due to Convulsions - Generalized ?Other conditions

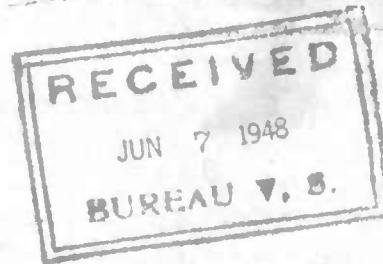
(Include pregnancy within 3 months of death)

Major findings of operations Date of op. Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of Where did injury occur? (City or town) (County) (State)Injured at home, farm, industry, public place (where?) Means of injury Injured at work? 23. SIGNATURE Sarah Washington Dawson M. D. or other Address 50 Peabody St Date signed 5/29/48



Within corporate limits
Weismer

MARGIN RESERVED FOR BINDING

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

T
VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d
04519

Reg. Dist. No. 4

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

Allegany

County

Cumberland

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Allegany Hospital

How long in hospital or institution?

10 hrs.

3. (a) FULL NAME

GEORGE WASHINGTON DAWSON

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

8. (b) Name of husband or wife

Rosella Martin

7. Birth date of deceased (mo., day, yr.)

July 22, 1878

B. (c) If alive, give age 68 years

8. AGE:

Years
69

Months
9

Days
12

If less than one day
hrs. min.

9. Birthplace

Keyser, W. Va.

(Town, county, and state)

10. Usual occupation

Trackman

11. Industry or business

Western Md. Railway

12. Name

Jacob Dawson

13. Birthplace

W. Va.

14. Maiden name

Julia Spencer

15. Birthplace

W. Va.

16. Informant

Mrs. Frank Travis

Address 1 Barncord St., Ridgeley, W. Va.

17. Burial

Date thereof May 7, 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory Mt. Zion Cem.

Location Near Short Gap, W. Va.

18. Funeral director

H. Wayne George

Address

Cumberland, Md.

May 6, 1948
(Date rec'd by registrar)

W. H. Tracy, M.D.
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State W. Virginia County Mineral

City or town Ridgely

(If outside city or town limits, write RURAL and give nearest town)

Street No. 6 Jones St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 4,

1948 11:57 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 4, 1948, to May 4, 1948

and that I last saw deceased alive on May 4, 1948

Immediate cause of death

Cerebral Hemorrhage

DURATION

18 hours

Due to Hypertensive Cardio-
vascular disease

7

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. H. Tracy, M.D.

M. D. or other

Address 122 Bedford, Cumberland Date signed 5/6/48

RECEIVED

MAY 11 1948

BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Dr. L. B.
04580

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County

Allegany

City or town

Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Allegany Hospital

How long in hospital or institution?

3. (a) FULL NAME

Ada Lechliter Dendrenos

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Gengeny Dendrenos

7. Birth date of deceased (mo., day, yr.)

July 22, 1922

6. (c) If alive, give age..... years

8. AGE: Years

25

Months

10

Days

5

If less than one day

hrs. min.

9. Birthplace

Shortsville, W. Va.

(Town, county, and state)

10. Usual occupation

Waitress

11. Industry or business

Victory Grill

MOTHER FATHER

12. Name

Gengeny Lechliter

13. Birthplace

W. Va.

14. Maiden name

Mary McCarthy

15. Birthplace

Baltimore, Maryland

16. Informant

Gengeny Dendrenos

17. Burial

(Burial, cremation, or removal. Which?)

Address 132 N. Centre St., Cumberland, Md.

Date thereof June 1, 1948
(month) (day) (year)

Cemetery or crematory

Rose Hill Cemetery

Location

Cumberland, Md.

18. Funeral director

Loris Stein, Inc.

Address

Cumberland, Maryland

19. Date rec'd by registrar

May 28, 1948

(Date rec'd by registrar)

W.H. Tracy, M.D.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

Allegany

City or town

Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 132 N. Centre St

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 27, 1948, 5:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 1, 1948, to May 27, 1948,

and that I last saw her alive on May 27, 1948.

Immediate cause of death

Surgical shock

Due to: following cesarean section

Due to: pregnancy uterine inertia

Other conditions: pregnancy uterine

DURATION

3 hours

(Include pregnancy within 3 months of death)

Major findings of operations: clavical fracture

cesarean section

Date of op. 5-27-48

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

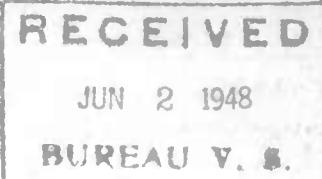
L. Kline (M.D.)

M. D. or other

Address

59 South St.

Date signed 5-27-48



Within corporate limits

M
Age

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15 M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04521

164C

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? All of life

Hospital, Institution, or street address where death occurred:

Buckingham Road, The Dingle

How long in hospital or institution?

3. (a) FULL NAME

Howard Harlen Dickey Jr.

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male White married

6.(b) Name of husband or wife Helen Dickey

6.(c) If alive, give age 38 years

7. Birth date of deceased (mo. day yr.) Sept. 12-1911

8. AGE: Years Months Days If less than one day
36 8 19 hrs. min.9. Birthplace Cumberland Md.
(Town, county, and state)

10. Usual occupation Kelly (Accountant)

11. Industry or business Automobile tires

12. Name Howard Harlen Dickey

13. Birthplace Philadelphia, Pa.

14. Maiden name Annie Gibson Roberts

15. Birthplace Cumberland Md.

16. Informant Mrs. Howard H. Dickey Jr.

Address 835 Buckingham Rd, City

17. Burial Date thereof May 4, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Cumberland, Md.

18. Funeral director John C. Holroyd

Address 125 S. Liberty St.

19. May 3 1948 W.H. Tracy, M.D.
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 835 Buckingham Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war World War 2

3. (b) Social Security Number

214-05-9363

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2 1948 at 12:05 m

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19.

and that I last saw him all Dead May 2 1948

Immediate cause of death

Intracranial hemorrhage due to a fracture of the skull at once

caused by a 38 caliber revolver bullet entering right temple area.

Wound self inflicted.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide suicide Date of 5-2-48

Where did injury occur? Home Cumberland Allegany Md. (City or town) (County) (State)

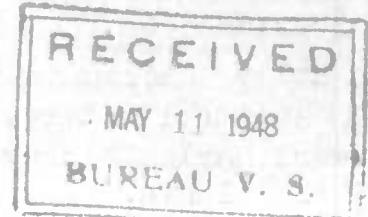
Injured at home, farm, industry, public place (where) Home

Means of injury 38 Caliber gun Injured at work? No.
Deputy Medical Examiner - Allegany Co.

23. SIGNATURE H.V. Deming M.D. H.V. Deming M.D.

M. D. or cert.

Address Cumberland Md. Date signed 5-3-48



Dr. Tolson

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04522

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1860

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Memorial Hospital
How long in hospital or institution? 30 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany
City or town Frostburg
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2 East Main Street
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

None

3. (a) FULL NAME

Jonas J. Durst

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Sally W. Layman

7. Birth date of deceased (mo., day, yr.) August 24, 1857
6.(c) If alive, give age 77 years

8. AGE: Years 90 Months 8 Days 28 If less than one day hrs. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation Retired - Funeral director

11. Industry or business Jerimah Durst

12. Name Jerimah Durst
13. Birthplace Maryland

14. Maiden name Anna Beechy
15. Birthplace Maryland

16. Informant Memorial Hospital

Address Cumberland, Maryland

17. Burial Date thereof May 24 1948
(Burial, cremation, or removal. Which?)

Cemetery or crematory Allegany Cemetery

Location Frostburg, Md.

18. Funeral director Louis Stein, Inc.

Address Cumberland, Md.

19. May 24, 1948 L.R. Brant, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 22, 1948 at 4:05A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-22 1948 to May 22 1948 and that I last saw him alive on May 21 1948

Immediate cause of death Malaria

Following

Due to Arthur Schloss

Fracture of femur

Duration 10 days

7

37 days

Other conditions
(Include pregnancy within 3 months of death)

Major findings or operations
Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 5/22/48

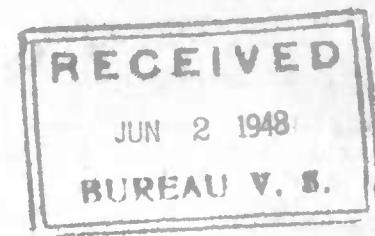
Where did injury occur? Frostburg, Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Home 6/20/48

Means of injury Tripped over a rug belt Injured at work?

23. SIGNATURE L.M. Wilson, Jr. M. D. or other

Address Cumberland, Md. Date signed 5-24-48



Within corporate limits HAWKINS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04523
462

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND MARYLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 DAYS

Hospital, institution, or street address where death occurred: MEMORIAL HOSPITAL

How long in hospital or institution? 17 DAYS

3. (a) FULL NAME

WILLIAM D. EDGAR

4. Sex MALE 5. Color or race WHITE 6.(a) Single, married, widowed, or divorced MARRIED

6.(b) Name of husband or wife DORA E. KAHL

7. Birth date of deceased (mo. day. yr.) FEBRUARY 4, 1888
6.(c) If alive, give age 43 years8. AGE: Years Months Days If less than one day
60 2 28 hrs. min.9. Birthplace PITTSBURGH PENNSYLVANIA
(Town, county, and state)

10. Usual occupation BODY & FENDER WORKER

11. Industry or business HARVEY GORTNER MOTOR SERV

12. Name WILLIAM H. EDGAR

13. Birthplace MARYLAND

14. Maiden name AMELIA KAHL

15. Birthplace MARYLAND

16. Informant MEMORIAL HOSPITAL

Address MEMORIAL AVE., CUMBERLAND, MD

17. Burial Date thereof May 5, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Grantville Cemetery

Location Grantsville Maryland

18. Funeral director William Rose Price

Address Myersdale Rd

19. May 3, 1948 W. Frank, M.D.
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County GARRETT

City or town GRANTSVILLE, MD
(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

214-03-7107

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 2, 1948 at 12:05 a.m.

21. I certify that death occurred on the date above stated; that I attended deceased from

Apr. 19, 1948 to May 1, 1948
and that I last saw him alive on May 1, 1948

Immediate cause of death Peritonitis DURATION

Due to Leaking Wound
peritoneal hemorrhage
Due to Obstetrics, CancerRecto sigmoid Colorectal
Due to conditions (Include pregnancy within 3 months of death)
Annular carcinoma
Recto sigmoid obstructionMain findings of operation
Autopsy results
Anatomical diagnosis
Recto sigmoid obstruction

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

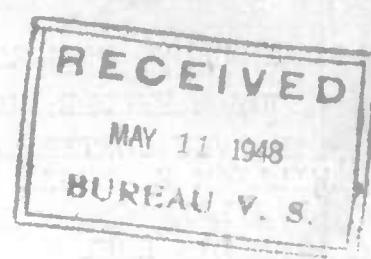
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M. D. or other

Address Oct. 1948



Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04524

CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County **Allegany County**

City or town **Cumberland, Maryland**
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? **13 years**

Hospital, institution, or street address where death occurred:
829 Braddock Road

How long in hospital or institution?

3. (a) FULL NAME

Mrs. LeOra Marian Eggleston

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	white	married

Female white married

6. (b) Name of husband or wife **Alan F. Eggleston**

6. (c) If alive, give age **69** years

7. Birth date of deceased (mo., day, yr.) **8/29/1879**

8. AGE: Years **68** Months **8** Days **29** If less than one day
hrs. min.

9. Birthplace **Fond-du-lac, Wisconsin**
(Town, county, and state)

10. Usual occupation **housewife**

11. Industry or business

FATHER 12. Name **Orin Lee Helmer**

MOTHER 13. Birthplace **Steete, N.Y.**

14. Maiden name **LeOra Childs**

15. Birthplace **Tuxton, Portland County, N.Y.**

16. Informant **Alan F. Eggleston**

Address **829 Braddock Road, Cumberland**

Burial 17. Date thereof **6/1/48**
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory **Cemetery (Rose Hill)**

Location **Fayette Street, Cumberland, Md.**

18. Funeral director

Address **125 S. Liberty St.**

19. Death certificate received by registrar **1948** **W.H. Faunt, M.D.**
(Date rec'd by registrar) (Registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State **Maryland** County **Allegany**

City or town **Cumberland**
(If outside city or town limits, write RURAL and give nearest town)

Street No. **829 Braddock Rd.**
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH **May 28** 1948 at **10³⁰ A.M.**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **March 46** to **May 28** 1948 and that I last saw her **alive on May 26** 1948.

Immediate cause of death **Parkinson's Disease**

DURATION **5 yrs.**

Due to.....

Due to.....

Other conditions **Carcinoma Cervix 1 yr.**

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE **Richard W. Treaster, Jr. M.D.**
M. D. Other

Address **Cumberland, Md.** Date signed **May 29 '48**



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04525
52 b

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH: Allegany
 County.....
 City or town..... Frostburg
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? All her life
 Hospital, institution, or street address where death occurred: Miners hospital
 How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State..... Maryland County..... Allegany
 City or town..... Frostburg
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 61 W. Main St.,
 (If rural, give LOCATION)

3. (a) FULL NAME CORA H. EVANS

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife..... Horace Evans

7. Birth date of deceased (mo., day, yr.) March 21, 1872

8. AGE: Years	Months	Days	If less than one day
76	1	22	hrs. min.

9. Birthplace..... Frostburg, Allegany, Maryland
 (Town, county, and state)

10. Usual occupation..... housewife
 home

11. Industry or business..... home

MOTHER FATHER
 12. Name..... George Hosken,
 13. Birthplace..... England

14. Maiden name..... Hannah Kear,
 15. Birthplace..... England

16. Informant..... Stella Hosken,
 Address..... Frostburg, Md.

17. Burial..... Date thereof..... May 15, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Allegany Cemetery,
 Location..... Frostburg, Md.

18. Funeral director..... J. R. Durst,
 Address..... Frostburg, Md.

19. 5-15 1948 Mrs. Nancy N. Rose
 (Date rec'd by registrar) Registrar

3. (b) Social Security Number none

MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 13 1948 at 105 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 13, 1948, to May 13, 1948, and that I last saw her alive on May 13, 1948.

Immediate cause of death..... Cerebral Embolism
 DURATION..... 30 hrs.

Due to..... Carcinoma of bladder
 1 yr.

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... J. R. Lattays M.D.
 M. D. or other.....

Date signed.....



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? about 3 min.

Hospital, Institution, or street address where death occurred:

On kitchen floor, 516 Necessity St.

How long in hospital or institution?

3. (a) FULL NAME

Robert Earl Fey

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male

White

married

6.(b) Name of husband or wife Bertha Nee

6.(c) If alive, give age 59 years

7. Birth date of deceased (mo. day, yr.)

Dec. 29- 1887

8. AGE: Years

Months

Days

If less than one day

60

4

17

hrs.

min.

9. Birthplace Cumberland Md.

(Town, county, and state)

10. Usual occupation Peter Pan cleaners.

11. Industry or business

12. Name John T. Fey

13. Birthplace Cumberland Md.

14. Maiden name Jennie Wilkinson

15. Birthplace Fredrick Md.

16. Informant Gen E Fey

Address Baltimore Pike, Cumberland Maryland
BurialDate thereof May 19 1948
(month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory Rose Hill Cemetery

Location Cumberland Maryland

18. Funeral director Louis Stein Jr.

Address Cumberland Maryland

19. Date rec'd by registrar May 19 1948

Carl Dauntz M.D.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md.

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 528 N. Mechanic St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

381-05-1051

MEDICAL CERTIFICATION

about

2D. DATE OF DEATH May 16

1948 at 7.40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to 19.....

and that I last saw h. im Dead May 16 1948

Immediate cause of death

Coronary occlusion

DURATION

at once

Due to Coronary sclerosis

Due to

Other conditions Hypertension

2 years

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

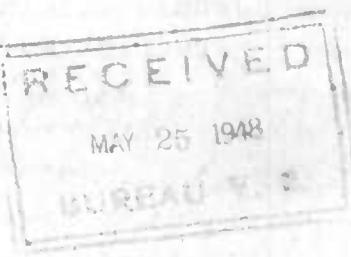
Injured at work?

Deputy Medical Examiner - Allegany H.V. Deming M.D. H.V. Deming M.D.

23. SIGNATURE H.V. Deming M.D. M. D. or other

Address Cumberland Md.

Date signed 5-17-48



Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04527

CERTIFICATE OF DEATH

Reg. Distr. No. 4

1. PLACE OF DEATH:

County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Sylvan Retreat

How long in hospital or institution? 5 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.

3.(a) FULL NAME

John R. Fulk

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male

White

Unknown

"

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo. day. yr.)

(Unknown) 1856

8. AGE:

Years 92

Months

Days

If less than one day

hrs. min.

9. Birthplace

(Town, county, and state) Virginia

10. Usual occupation

Unknown

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant Sylvan Retreat

Address Cumberland, Maryland

17. Burial

Date thereof June 6, 1948

(Burial, cremation, or removal, Which?)

(month) (day) (year)

Cemetery or crematory Allegany County Cemetery

Location Cumberland, Maryland

18. Funeral director

John J. Hafer

Address

Cumberland, Maryland

19. Date rec'd by registrar

June 4, 1948

W.H. Brant, M.D.
Registrar

(Date rec'd by registrar)

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

2D. DATE OF DEATH

May 30

1948 at 7:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec.

1946 to May 30

1948

and that I last saw him alive on May 28 1948

Immediate cause of death

Myocardial failure

Due to Chronic myo. carditis

Due to Senility

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address 110 S. Centre St. Date signed 6-4-48

2981
26
8461



Within corporate limits

DR. R. WILLIAMS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04528
830

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND, MD.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 DAYS

Hospital, Institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution? 2 DAYS

3. (a) FULL NAME

MRS. LYDIA GARNER

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

FEMALE WHITE WIDOWED

6. (b) Name of husband or wife BERT B. GARNER

7. Birth date of deceased (mo., day, yr.) AUGUST 18, 1875

8. AGE: Years Months Days If less than one day
72 9 5 hrs. min.9. Birthplace WEST VIRGINIA
(Town, county, and state)

10. Usual occupation HWFE

11. Industry or business

12. Name SAMUEL SISLER

13. Birthplace WEST VIRGINIA

14. Maiden name NANCY HAYES

15. Birthplace WEST VIRGINIA

16. Informant MEMORIAL HOSPITAL

Address CUMBERLAND, MARYLAND

17. Burial: Date thereof May 26, 48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Terra Alta.

Location Terra Alta. w. Va.

18. Funeral director J. F. Collins

Address Terra Alta. w. Va.

19. May 25, 1948 W. H. Davis, M.D.
(Date recd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

Street No. 432 WALNUT STREET

(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 23, 1948 at 7:35A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

5/22/48 19. to 5/23/48 19.

and that I last saw her alive on 5/23/48 19.

Immediate cause of death

Cerebral Hemorrhage

DURATION

Due to

Hyper tension

Due to

Arteriosclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

W. H. Davis, M.D.
Med. College of Maryland 5/24/48

RECEIVED

JUN 2 1948

BUREAU V. S.

Within corporate limits

DR. GRACIE

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04529

181

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County.....
ALLEGANY

City or town.....
CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....
2 DAYS

Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL

How long in hospital or institution?.....
2 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State.....
MARYLAND County.....
GARRETT

City or town.....
ROUTE #1, OAKLAND
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

2D. DATE OF DEATH.....
MAY 13, 1948 19..... at **2:45 A.M.**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
May 11 1948, to **May 13** 1948
and that I last saw her alive on **May 12** 1948

Immediate cause of death.

Schott
Due to *Burns - 1-2-3 degree*
7 toes arms + today

Due to.

Other conditions.

(Include pregnancy within 3 months of death)

Major findings of operations.

Date of op.

Autopsy results.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

MD. 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... *Accident* Date of **5/11/48**

Where did injury occur? *Garnett Co Md* (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) *Home*

Means of Injury *Use of pot of hot coffee* Injured at work?

23. SIGNATURE

W.A. Gracie M.D.

M. D. or other

Address..... *Cumberland Md* Date signed **May 13-48**

4. Sex	5. Color or race	B.(a) Single, married, widowed, or divorced
FEMALE	WHITE	SINGLE

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo. day. yr.).....
MARCH 3, 1947

8. AGE: Years	Months	Days	If less than one day
1	2	10	hrs. min.

9. Birthplace.....
MARYLAND (Town, county, and state)

10. Usual occupation.....
Child

11. Industry or business

12. Name.....
WILLIAM GEORGE

13. Birthplace.....
WEST VIRGINIA

14. Maiden name.....
UNA REAMS

15. Birthplace.....
WEST VIRGINIA

16. Informant.....
MEMORIAL HOSPITAL

Address.....
MEMORIAL AVE., CUMBERLAND,

17. Burial.....
(Burial, cremation, or removal. Who?) *Taylor Service Corp* Date thereof *May 15, 1948*

Cemetery or crematory.....
St. #1, Oakland, Md

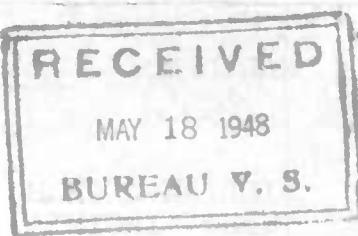
Location.....
Emory Bolden

18. Funeral director.....

Address.....
Oakland md

19. May 14, 1948. *W.H. Frazey, M.D.* Registrar

(Date rec'd by registrar)



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

04530

Reg. Dist. No. 9

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? years

Hospital, institution, or street address where death occurred

75 Armstrong St.

How long in hospital or institution?

3. (a) FULL NAME

Alice Caroline Tracy

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female White Widowed

6. (b) Name of husband or wife

Robert Tracy

7. Birth date of deceased (mo., day, yr.)

Feb. 20 - 1863

6. (c) If alive, give age years

8. AGE: Years

Months

Days

If less than one day

85

3

3

hrs.

min.

9. Birthplace

Oakwood Paulding, Ohio

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

12. Name

Unknown

13. Birthplace

14. Maiden name

Futter

15. Birthplace

Oakwood, Paulding Co. Md.

16. Informant

Mrs. Wm. Shuey

Address

15 Armstrong St. Bldg. #1

17. Burial

Burial

(Burial, cremation, or removal. Which?)

Date thereof
(month) (day) (year)
5 - 25 - 1948

Cemetery or crematory

Allegany Cemetery

Location

Front of lot

18. Funeral director

Jackie Draper

Address

Washington, D.C.

19. 5-26-48 (Date rec'd by registrar)

19. 48 (Date of death)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md. County Allegany

City or town

P. O. Box Front St. (If outside city or town limits, write RURAL and give nearest town)

Street No.

75 Armstrong St. (If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 23 1948 at 2 o'clock PM

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from

April 1948 to May 23, 1948, and that I last saw her alive on May 21, 1948.

Immediate cause of death

Chronic Myocarditis

DURATION

7

Due to

Sensitivity

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

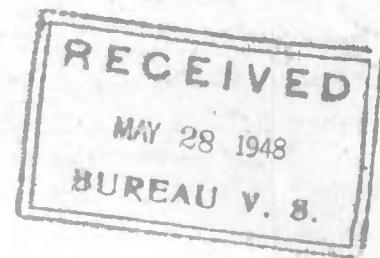
Means of injury

Injured at work?

23. SIGNATURE

WOM Lane MD
Frederick MD Date signed 5-24-48

M. D. or other



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and briefly.

Dr. Whitworth

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1578
04531

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: Allegany
County: Cumberland
City or town: (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution? 2 days

3. (a) FULL NAME

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: _____

7. Birth date of deceased (mo., day, yr.) May 18 1948

8. AGE: Years Months Days if less than one day
- - - 2 .hrs. .min.

9. Birthplace: Cumberland, Allegany, Md.
(Town, county, and state)

10. Usual occupation: _____

11. Industry or business: _____

FATHER 12. Name: Boyd Grand staff
13. Birthplace: Piedmont, W. Va.

MOTHER 14. Maiden name: Katherine McCormick

15. Birthplace: Beryl W. Va.

16. Informant: Boyd Grand staff

Address: Westerport, Md.

BURIAL 17. Burial Date thereof: May 21, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: St. Peters Cemetery

Location: Westerport, Md.

18. Funeral director: Ellsworth A. Boal

Address: Westerport, Md.

19. May 21, 1948
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

for newborn infants give residence of mother)
State: Maryland County: Allegany

City or town: Westerport (If outside city or town limits, write RURAL and give nearest town)

Street No.: 109 Front St
(If rural, give LOCATION)

2.(a) If veteran, name war: _____

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 20, 1948 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 18 May 1948 to 20 May 1948 and that I last saw him alive on 20 May 1948.

Immediate cause of death: Congenital Atrial septal defect
Due to: RT Murray

Due to: _____

Other conditions: Wyo Spokes
Spencer Barbara - Sonnen.
(Include pregnancy within 3 months of death)

Major findings of operations: _____ Date of op. _____

Autopsy results: _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: _____ Date of: _____

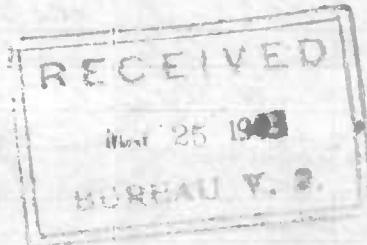
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury: _____ Injured at work? _____

23. SIGNATURE: Fuller B. Whitworth, M.D. or other

Address: 112 Bedford St. Date signed: 20 May 1948



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04532
94a

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

City Hall, N. Center St.

How long in hospital or institution?

3. (a) FULL NAME

Samuel E. Griminger

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male

white

married

6. (b) Name of husband or wife

Edith T. Hause

7. Birth date of deceased (mo., day, yr.)

Sept 8, 1884

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Cumberland, Md.

(Town, county, and state)

10. Usual occupation

City Clerk

11. Industry or business

Cumberland, Md.

MOTHER FATHER

12. Name

Samuel Griminger

13. Birthplace

Maryland

Monsey

14. Maiden name

Maryland

15. Birthplace

Monsey

16. Informant

Edith T. Griminger

Address

207 Piedmont Ave, Cumberland

17. (Burial, cremation, or removal. Which?)

Burial

Date thereof

May 7, 1941

(month) (day) (year)

Cemetery or crematory

Hillcrest Burial Park

Location

Cumberland, Md.

18. Funeral director

Louis Stein, Inc.

Address

Cumberland, Md.

19. (Date rec'd by registrar)

May 5, 1948

W.H. Frantz, M.D.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md.

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 207 Piedmont Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

220-16-6229

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4

1948 at 3:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..., to 19...

and that I last saw h. im all Dead May 4

19...

Immediate cause of death

Coronary occlusion

DURATION

about
6 Mo..

Due to Coronary sclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

Deputy Medical Examiner Allegany Co.

23. SIGNATURE H.V. Deming M.D.

M.D. of

Address Cumberland, Md.

Date signed 5-4-48

RECEIVED
MAY 11 1948
BUREAU V. S.

Within corporate limits

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04534

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County..... Allegany
City or town..... Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 5Yrs

Hospital, institution, or street address where death occurred:

3 Fayette St.

How long in hospital or institution?.....

3. (a) FULL NAME

William H Hall

4. Sex..... 5. Color or race..... 6. (a) Single, married, widowed, or divorced

Male Colored Divorced

Manda Brown

6. (b) Name of husband or wife.....

6. (c) If alive, give age..... years

7. Birth date of deceased (mo. day. yr.)..... 5/31/1862

8. AGE: Years Months Days If less than one day
86 0 0 hrs. min.9. Birthplace..... Cumberland, Maryland
(Town, county, and state)

10. Usual occupation..... Janitor - Retired

11. Industry or business

12. Name..... George Hall
13. Birthplace..... Unknown14. Maiden name..... Minerva Brown
15. Birthplace..... Unknown16. Informant..... Virginia Williams
Address..... 13 Fayette St. Cumb. Md.17. Burial..... Date thereof..... June 2, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory..... Summer Cemetery
Location..... Cumberland, Md.18. Funeral director..... John D. McPherson
Address..... 115 S Liberty St. Cumberland, Md.Date rec'd by registrar..... June 2, 1948
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Maryland County..... Allegany

State..... City or town..... Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3 Fayette St.

(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 31, 1948 at 7:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 28, 1948, to May 31, 1948

and that I last saw him alive on May 28, 1948

Immediate cause of death..... Generalized arteriosclerosis. Heart disease

Due to.....

Due to.....

Other conditions..... Senility

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE..... B. McPherson, M.D.

D. or other

Address..... 4 Grand St.

Date signed..... June 1, 1948



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04535

131a

CERTIFICATE OF DEATH

Reg. Dist. No. 4

Within corporate limits

The correct age

M

is especially important.

Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County..... Allegany
 City or town..... Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 years

Hospital, institution, or street address where death occurred:

Memorial Hospital

How long in hospital or institution? 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... Maryland County..... Allegany

City or town..... Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 911 Brentwood Street
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

214-05-9230

MEDICAL CERTIFICATION

May 2, 48 at 5:05 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 9 47 to May 2 48
 and that I last saw him alive on *May 2 48*

Immediate cause of death.....

DURATION

*Cardiovascular
renal disease*

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

*none*Date of op. *none*

Autopsy results.....

none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

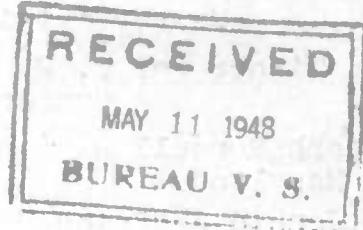
Means of injury.....

Injured at work?

23. SIGNATURE

W. F. Williams
 M. D. Other
 Cumberland, Md. Date signed 5/3/48

19. May 4, 1948 W.R. Prante, M.D.
(Date rec'd by registrar) Registrar



Dr. T. Durrett

WITH UNFADEING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04536

159

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

13 hours 13 minutes

How long in above place of death?

Hospital, Institution, or street address where death occurred:
Memorial Hospital

13 hours 13 minutes

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State West Virginia County Mineral

City or town Ridgeley
(If outside city or town limits, write RURAL and give nearest town)Street No. 18 Johns Street
(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (b) Social Security Number

None

3. (a) FULL NAME

Baby Boy Hansrote

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife.....

6.(c) If alive, give age..... years

7. Birth date of deceased (mo. day, yr.) May 16, 1948

8. AGE: Years	Months	Days	If less than one day
			13 hrs. 13 min.

9. Birthplace Cumberland, Allegany, Md.
(Town, county, and state)

10. Usual occupation Newborn infant

11. Industry or business

12. Name Glen R. Hansrote

13. Birthplace Maryland

14. Maiden name Verna Ruth Lewis

15. Birthplace West Virginia

16. Informant Memorial Hospital

Address Cumberland, Maryland

17. Burial Date thereof May 17, 1948

(Burial, cremation, or removal. Which?)
of month (day) (year)

Cemetery or crematory Greenmount Cemetery

Location Cumberland, Md.

18. Funeral director J. H. Hopper

Address Cumberland, Md.

19. May 17, 1948 M. D. or

(Date rec'd by registrar) W. L. Trout, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16, 1948, at 2:17 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 16, 1948 to May 16, 1948

and that I last saw him alive on May 16, 1948

Immediate cause of death Premature 30 weeks

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE George L. Trout, M.D.

Date signed 5/17/48

Address



M MARGIN RESERVED FOR BINDING
I PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

R. F. Williams

CERTIFICATE OF DEATH

Reg. Dist. No. 4

93d

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 yrs

Hospital, Institution, or street address where death occurred: 601 Washington St.

How long in hospital or institution?

3. (a) FULL NAME

R. Mason Hill

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Florence Reed

7. Birth date of deceased (mo., day, yr.)

December 22, 1871

6. (c) If alive, give age..... years

8. AGE: Years

7

Months

6

Days

8

If less than one day

hrs.

min.

9. Birthplace

Frostburg, Maryland

(Town, county, and state)

10. Usual occupation

Clark

11. Industry or business

Allegany County Courthouse

MOTHER FATHER

12. Name

Thomas Hill

13. Birthplace

Ireland

14. Maiden name

Elizabeth Mason

15. Birthplace

Penn.

16. Informant

Florence Hill

Address

601 Washington St, Cumberland, Md

17. Burial

Cremation

Date thereof

June 1, 1948

(month)

(day)

(year)

Cemetery or crematory

Allegany Cemetery

Location

Frostburg, Maryland

18. Funeral director

Louis Stein, Inc.

Address

Cumberland, Md

19. Date rec'd by registrar

June 1, 1948

(Date rec'd by registrar)

W. J. Tracy, M.D.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Maryland Allegany

City or town.....

Cumberland (If outside city or town limits, write RURAL and give nearest town)

Street No.....

601 Washington St

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 30, 1948 at 1:10 A.M.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from

Jan 31, 1948, to May 30, 1948, and that I last saw him alive on

Immediate cause of death

5/27/48

DURATION

Due to

Chronic Myocardial Degeneration

Due to

Other conditions

(Include pregnancy within 6 months of death)

Major findings of operations

None None

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of

Where did injury occur

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John F. Williams

M. D. or other

Address

Cumberland, Md Date signed 6/1/48

Mr. Stein



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04538
93e

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

Allegany

County

Cumberland

City or town

(If outside city or town limits, write RURAL and give nearest town)

82 Yrs 11 Mo 4 Days

How long in above place of death?

Hospital, Institution, or street address where death occurred:

226 Columbia St

How long in hospital or institution?

3. (a) FULL NAME

Ida May Hilleary

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female**White****Married****Richard P. Hilleary**

6. (b) Name of husband or wife

6. (c) If alive, give age **82** years

7. Birth date of deceased (mo., day, yr.)

June 18 1865

8. AGE:

Years

Months

Days

If less than one day

82**11****4**

hrs.

min.

9. Birthplace

Cumberland, Allegany Co., Maryland

(Town, county, and state)

10. Usual occupation

House**"**

11. Industry or business

"

12. Name

Casper Cassen

13. Birthplace

Germany

14. Maiden name

Elizabeth Bennett

15. Birthplace

Cumberland, Md.

16. Informant

Mrs Elizabeth Cassen

Address

435 Columbia St, Cumberland, Md.

17. Burial

Date thereof **5/25/48**

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Rose Hill Cemetery

Location

Cumberland, Md.

18. Funeral director

William H. Kight

Address

Cumberland, Md.19. **May 24, 1948**

(Date rec'd by registrar)

Carl F. Frank, M.D.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Maryland

County

Allegany

State

City or town

Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No.

226 Columbia St

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

2D. DATE OF DEATH

May 22,

1948 at 5:15 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 19 1948 to May 22 1948
and that I last saw him alive on **May 22** 1948

Immediate cause of death

Acute myocardial insufficiency

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Charlotte B. Gardner

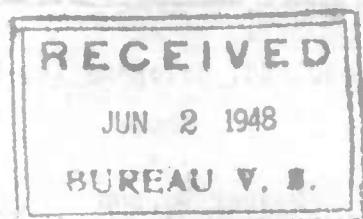
M. D. or other

Address

Cumberland, Md.

Date signed

5-22-48



DR. McFARLAND

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

117 b

04539

Reg. Dist. No. 4

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
County ALLEGANY

City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 DAYS

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution? 7

3. (a) FULL NAME

MR. MAURICE E. HINDS

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

MALE	WHITE	MARRIED
------	-------	---------

6.(b) Name of husband or wife BERTHA B. JOHNSTON

7. Birth date of deceased (mo. day, yr.) JANUARY 23, 1889
6.(c) If alive, give age 57 years

8. AGE: Years Months Days If less than one day
59 3 14 22 hrs. min.

9. Birthplace WEST VIRGINIA
(Town, county, and state)

10. Usual occupation BLOCK # 3

11. Industry or business CELANESE CORP. OF AMERICA

MOTHER FATHER MR. JOHN F. HINDS

13. Birthplace WEST VIRGINIA

14. Maiden name IDA MECHEM

15. Birthplace MARYLAND

16. Informant MEMORIAL HOSPITAL

Address MEMORIAL AVE., CITY

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/24/48
(month) (day) (year)

Cemetery or crematory Greenway Cemetery

Location Berkeley Springs, W. Va.

18. Funeral director John J. Hoffer

Address Cumberland, Md.

19. May 8, 1948 Dr. Trautz, M.D.
(Date rec'd by registrar) Registrars

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CRESAP TOWN, MD.
(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

214-05-5529

MEDICAL CERTIFICATION

2D. DATE OF DEATH MAY 7, 1948 at 1:10 A.M.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from

May 8, 1948 to May 8, 1948

and that I last saw him alive on May 8, 1948

Immediate cause of death Myocardial insufficiency

Due to Peritonitis

Due to Peritonitis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

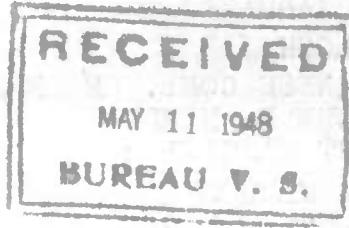
Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

M. D. or other
Address Date signed 6/7/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04540
93d

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
 City or town Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

634 Columbia Ave

How long in hospital or institution?

3. (a) FULL NAME

Lilley May Horchler

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

female white married

6. (b) Name of husband or wife John Horchler

7. Birth date of deceased (mo., day, yr.) Oct. 18- 1886 / 885 6. (c) If alive, give age 62 years

8. AGE: Years Months Days If less than one day
61 7 5 hrs. min.9. Birthplace Twiggtown Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name John Wilmont

13. Birthplace Md.

14. Maiden name Niama Twigg

15. Birthplace Md.

16. Informant John H. Horchler

Address Cumberland Md.

Burial

17. Date thereof May 25, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cem.

Location Cumberland, Md.

18. Funeral director Louis Stein Inc.

Address Cumberland, Md.

19. May 24, 1948
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 634 Columbia Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH May 23 1948 at 3:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19.

and that I last saw her alive on May 23 1948.

Immediate cause of death

Chronic myocarditis

DURATION

about
2 yrs.

Due to

Due to

Other conditions Hypertension & edema of lower legs.
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Deputy Medical Examiner Allegany

23. SIGNATURE H. V. Deming M.D. H. V. Deming M.D.

M. other

Address Cumberland Md. Date signed 5-23-48

RECEIVED
JUN 2 1948
BUREAU Y. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Dr. Reeves 04541

CERTIFICATE OF DEATH

Reg. Dist. No. 6

M

1. PLACE OF DEATH:

County Allegany
City or town Barton

(If outside city or town limits, write RURAL and give nearest town)

60 years

How long in above place of death?

Hospital, Institution, or street address where death occurred:

State Road

How long in hospital or institution? - - - - -

3. (a) FULL NAME

SARAH ANN HYDE

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

White

Widow

6. (b) Name of husband or wife

William Hyde, Sr.

6. (c) If alive, give age - - - years

October 6, 1870

7. Birth date of deceased (mo. day, yr.)

8. AGE: Years Months Days If less than one day

77 7 3 hrs. min.

9. Birthplace Lonaconing, Allegany, Maryland
(Town, county, and state)

10. Usual occupation Domestic

11. Industry or business Own home

12. Name William KirkPatrick

13. Birthplace Scotland

14. Maiden name Janette Cleland

15. Birthplace Scotland

16. Informant Mr. Chester Hyde

Address Barton, Maryland

17. Burial Date thereof May 11, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Laurel Hill Cemetery

Location Moscow, Maryland

18. Funeral director Ellsworth S. Boal

Address Westernport, Md.

19. May 11, 1948 Registrar
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Barton
(If outside city or town limits, write RURAL and give nearest town)

Street No. State Road

(If rural, give LOCATION)

2.(a) If veteran, name war - - - - -

3. (b) Social Security Number - - - - -

MEDICAL CERTIFICATION

20. DATE OF DEATH May 9, 1948 19 at 6:00 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 1, 1948, to May 9, 1948
and that I last saw him alive on May 6, 1948

Immediate cause of death

Chronic myocarditis
Chronic gall bladder disease

DURATION

1 yr.
6 mos

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

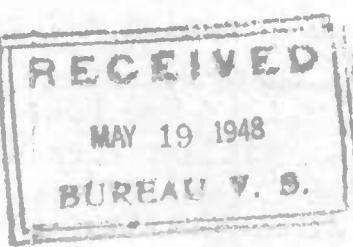
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other
Westergaard M.D. Date signed 10/14/81
Address



04542

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

CERTIFICATE OF DEATH

Reg. Dist. No. 7

1. PLACE OF DEATH:

County Allegany

City or town Cumberland Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Algonquin Hotel, Washington St.

How long in hospital or institution?

3. (a) FULL NAME

Robert Jackson

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male

white

single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age years

Aug. 12th 1880

8. AGE:

Years

Months

Days

If less than one day

67 8 21

hrs.

min.

9. Birthplace Lonaconing Md.

(Town, county, and state)

10. Usual occupation Clerk of Allegany Circuit Court

11. Industry or business

12. Name Thomas Jackson

13. Birthplace

Scotland

14. Maiden name Janet Stevenson

15. Birthplace

Scotland

16. Informant Helen Jackson

Address Washington, D. C.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof May 6 (month) (day) (year) 1948

Cemetery or crematory Oak Hill Cemetery

Location Lonaconing Md

18. Funeral director W. E. Eichhorn

Address Lonaconing Md

19. May 5 1948 (Date rec'd by Registrar)

W. P. Frantz, M.D. (Registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. Algonquin Hotel, Washington St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION about

20. DATE OF DEATH May 3 1948 at 2 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

19. to 19.

and that I last saw h. im. alive on Dead May 3 1948

Immediate cause of death

Coronary occlusion

DURATION

at once

Due to coronary sclerosis

Court.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE H. V. Deming M.D. H. V. Deming M.D. M. D. or other

Address Cumberland Md. Date signed 5-3-48

RECEIVED
MAY 11 1948
BUREAU V. S.

Evidence for change of
birth date shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04543

HAM NO. G 116 JUN 10 1948 CERTIFICATE OF DEATH

164c
Reg. Dist. No. 9

1. PLACE OF DEATH:

County Allegany

City or town Frostburg Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

79 Linden St.

How long in hospital or institution?

3. (a) FULL NAME

Harry Fredick Johns

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

male white married

6.(b) Name of husband or wife Ruth Fram Johns

6.(c) If alive, give age years

7. Birth date of deceased (mo. day, yr.) Sept. 2-1906 1905

8. AGE: Years Months Days If less than one day
42 8mo 6 hrs. min.

9. Birthplace Borden Mines Md.
(Town, county, and state)

10. Usual occupation Engineering Dept.

Clerk

11. Industry or business

12. Name John Johns

13. Birthplace Borden Mines Md.

14. Maiden name Annie Brode

15. Birthplace Frostburg Md.

16. Informant Mrs Ruth F. Johns

Address Frostburg Md.

17. Burial Date thereof May 31st 1948
(Burial, cremation, or removal. Which?)

Cemetery or crematory Allegany Cemetery

Location Frostburg, Md.

18. Funeral director Jacob Hafer

Address Frostburg, Md.

19. 5-31 1948

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md.

County Allegany

City or town Frostburg

(If outside city or town limits, write RURAL and give nearest town)

Street No. 79 Linden St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

220-16-5836

MEDICAL CERTIFICATION

20. DATE OF DEATH May 28

19 48, at 4.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19.

and that I last saw h. im all Daad May 28

19 48

Immediate cause of death

Intracranial hemorrhage due to at a self inflicted(12 guage shot-once gun)wound in right orbital region.

Due to

Other conditions Fractured bones, right side of face & head.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, tell in the following:

Accident, suicide, or homicide Suicide Date of 5-28-48

Where did injury occur? Frostburg Allegany Md.

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) home

Means of Injury as above

Injured at work?

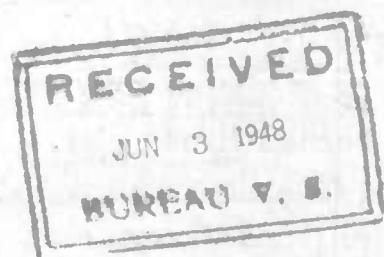
Deputy Medical Examiner - Allegany Co.

23. SIGNATURE H. V. Deming M.D. H. V. Deming M.D.

M. D. (initials)

Address Cumberland Md.

Date signed 5-29-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04544
94a

CERTIFICATE OF DEATH

Reg. Dist. No. 8

1. PLACE OF DEATH:

County

Allegany

Lonaconing, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 71 yrs

Hospital, institution, or street address where death occurred:

Bradley St

How long in hospital or institution?

3. (a) FULL NAME

Daniel Jones

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male

White married

6.(b) Name of husband or wife Clara Fazalaker Jones

7. Birth date of deceased (mo. day. yr.)

Feb. 24/1877

6.(c) If alive, give age 68 years

8. AGE:

Years Months Days If less than one day
71 2 10 hrs. min.

9. Birthplace

Lonaconing, Md.

(Town, county, and state)

10. Usual occupation

Janitor

11. Industry or business

Williams Jones

12. Name

Walter

13. Birthplace

Rebecca Bradley

14. Maiden name

Scotland

15. Birthplace

Clara Fazalaker Jones (wife)

16. Informant

Lonaconing, Md.

Address

Burial

Date thereof May 7, 1948

(Burial, cremation, or removal, Which?)

Cemetery or crematory

Allegany Cemetery

Location

Posthouse Rd.

18. Funeral director

J.W. Jackson

Address

Lonaconing, Md.

19. Date rec'd by registrar

18-48 Janette M. Brad

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md

County Allegany

City or town Lonaconing, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. Dudley St

(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (b) Social Security Number

220-10-2657

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 4, 1948, at 2:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... to 19...

19...

and that I last saw h. m. a. Dead May 4, 1948

Immediate cause of death

Coronary occlusion

at home

Due to Coronary occlusion

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Deputy Medical Examiner - Allegany

Injured at work

23. SIGNATURE of J.V. Danning M.D.

M. D. or other

Address Cumberland, Md. Date signed 5-4-48



Within corporate limits

M
Age

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04545

10

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County..... Allegany

City or town..... Cumberland

(If outside city or town limits, write RURAL and give nearest town)

15 Yrs 2 Mo 22 Days

How long in above place of death?

Hospital, institution, or street address where death occurred:

323 Emily Street

How long in hospital or institution?

3. (a) FULL NAME

William Bernard Kabosky

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

February 15 1933

8. AGE:

Years
15Months
2Days
22

It less than one day

hrs.
.....min.
.....

9. Birthplace.....

(Town, county, and state)
Cumberland, Allegany Co., Md

10. Usual occupation.....

Student

11. Industry or business

MOTHER FATHER

12. Name..... Thomas Kabosky

13. Birthplace..... Cumberland, Md.

MOTHER FATHER

14. Maiden name..... Marion

15. Birthplace.....

Tyzentaker

Cumberland, Md.

16. Informant.....

Mrs Marion Weimer

Address

323 Emily St, Cumberland, Md.

17. Burial

(Burial, cremation, or removal, Which?)

Date thereof..... 5/10/48

(month) (day) (year)

Cemetery or crematory

St. Peter & Paul Cemetery

Location

Cumberland, Md.

18. Funeral director

William H. Kight

Address

Cumberland, Md.

19. Date rec'd by registrar

May 10, 1948

W.R. Lantz, M.D.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Allegany

City or town..... Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 323 Emily Street

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 7

1948 at 5-30P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Apr. 28, 1948, to May 7, 1948, and that I last saw him alive on May 7, 1948.

Immediate cause of death.....

Sifphleria

DURATION

2 weeks.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

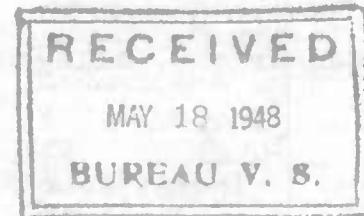
Injured at work?

23. SIGNATURE.....

George J. Surreo

M. D. or other

Address..... Cumberland Date signed..... May 7, 1948.



I PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04546

1702

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Memorial Hospital

How long in hospital or institution? 2 hrs or 25 minutes

3. (a) FULL NAME

ROY KENNELL

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

MALE

WHITE

MARRIED

6.(b) Name of husband or wife NAOMI EMERICK

7. Birth date of deceased (mo. day, yr.)

August 24th 1891

6.(c) If alive, give age XY 55 years

8. AGE:

Year

Month

Days

If less than one day

56

8

12

hrs.

min.

9. Birthplace PENNA

(Town, county, and state)

10. Usual occupation SAW MILL WORKER

11. Industry or business

12. Name WILLIAM KENNELL

13. Birthplace PENNA

14. Maiden name ETHEL LEPLEY

15. Birthplace PENNA

16. Informant

Mrs. Naomi Emerick Kennell

Address

Hyndman, Pa R.F.D.

Burial

(Burial, cremation, or removal. Which?)

Date thereof 5 11 48
(month) (day) (year)

Cemetery or crematory

Camps

Location

Hyndman, Pa R.F.D. #1

18. Funeral director

Harvey H. Ziegler

Address

Hyndman, Pa

19. Date rec'd by registrar

May 19 48 W. Faust M.D.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State PENNA

County BEDFORD

City or town HYNDMAN

(If outside city or town limits, write RURAL and give nearest town)

Street No.

Route #1

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH May 6

19 48 at 1 a.m. 35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 to 19

and that I last saw h. im.alive dead May 6

19 48

Immediate cause of death Severe cerebral contusions and shock

DURATION
about 1 1/2 day

Due to

Due to

Other conditions Fracture of pubic bone and left femur
(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide Accident

Date of 5-4-48

Where did injury occur? Hyndman Bedford Pa

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Our mountain

Means of Injury Run over by truck injured at work? 5-4-48

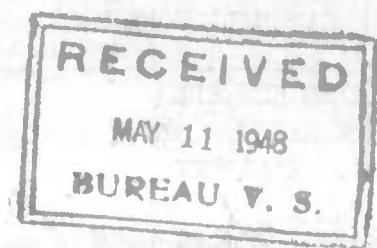
Deputy Medical Examiner Allegany

23. SIGNATURE H.V. Deming M.D. H.V. Deming M.D.

M. D. or other

Address Cumberland Md.

Date signed 5-6-48



STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. _____

State of Maryland

1316
six * 6

1. PLACE OF DEATH:
 (a) County Allegany
 (b) City or town Rural near Dawson
 (If outside city or town limits, write RURAL)
 (c) Name of hospital or institution:
 R#3 Keyser, W. Va.
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution
 In this community 6 years
 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Maryland (b) County Allegany
 (c) City or town Rural near Dawson
 (If outside city or town limits, write RURAL)
 (d) Street No. (R#3 Keyser, W. Va.)
 (If rural, give location)
 (e) If foreign born, how long in U. S. A? _____ years.

3. (a) FULL NAME Lora Childress Kesner

3. (b) If veteran, name war no
No. no4. Sex female 5. Color or white
6. (a) Single, widowed, married, divorced widow6. (b) Name of husband or wife James Cecil Kesner
6. (c) Age of husband or wife if alive died 1937 years7. Birth date of deceased July 11th 1877
(Month) (Day) (Year)8. AGE: Years Months Days
70 9 20
If less than one day hr. min.9. Birthplace Pendleton Co., W. Va.
(City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business housewife

12. Name John Adam Harper

13. Birthplace Va.
(City, town, or county) (State or foreign country)

14. Maiden name Suzanna Baker

15. Birthplace Va.
(City, town, or county) (State or foreign country)16. (a) Informant's own signature Miss Hazel Kesner
(b) Address R#3, Keyser, W. Va.17. (a) Burial (b) Date thereof May 4 48
(Burial, cremation, or removal) Dawson Cemetery
(c) Place; burial or cremation Dawson, Md.18. (a) Signature of funeral director Rogers Funeral Home
(b) Address Keyser, W. Va.19. (a) May 4, 1948 (b) May 4, 1948
(Date received local registrar) (Registrar's signature)MEDICAL CERTIFICATION
20. Date of death: Month May day 1st
year 1948 hour 2.45 p.m. minute21. I hereby certify that I attended the deceased from Aug 1
1947, to April 28, 1948;
that I last saw her alive on April 28, 1948;
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary edema Duration day

Due to Myocarditis with desquamation

Due to Nephritis chronic

Other conditions (Include pregnancy within 3 months of death) PHYSICIAN

Major findings:
Of operations no

Of autopsy no

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) no

(b) Date of occurrence

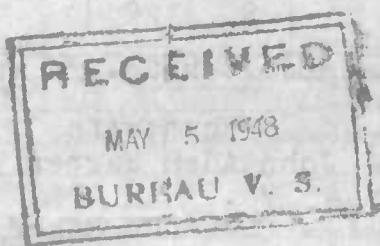
(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (c) Means of injury

23. Signature M. D. #111 (M. D. #111)

Address Keyser, W. Va. Date signed 5/4/48



Within corporate limits

PLEASE WRITE PLAINLY.
WITH UNFADING INK.
is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

05498

DR. JACOBSON

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

ALLEGANY

County

CUMBERLAND

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

1 HOUR 45 years.

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution?

1 HOUR

3. (a) FULL NAME

MR. FLOYD E. KUNES, SR.

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

MALE

WHITE

WIDOWED

6.(b) Name of husband or wife

MRS. ESTELLA THOMAS

7. Birth date of deceased (mo., day, yr.)

JANUARY 21, 1878

6.(c) If alive, give age years

8. AGE:

Years
70Months
3Days
20

If less than one day

hrs.

min.

9. Birthplace

LANCASTER COUNTY, PENNA.

(Town, county, and state)

10. Usual occupation

RETIRED B & O ENGINEER

11. Industry or business

MOTHER FATHER

12. Name

WM. HENRY KUNES

PENNA.

13. Birthplace

PENNA.

14. Maiden name

ELLEN D'LONG

PENNA.

16. Informant

Mrs. William Donaldson

Address Lake, Cumberland, Md.

17. Burial!

(Burial, cremation, or removal. Which?)

Date thereof JAN 13, 1948

(month) (day) (year)

Cemetery or crematory Hyndman Cemetery

Location Hyndman, Pa.

18. Funeral director

Johns J. Weller

Address Ceredale, Ind.

19. May 13, 1948 W. R. Frantz, M.D.

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

MARYLAND County ALLEGANY

City or town CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

Street No. 882 Gapbart Drive

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 11 1948 1:55 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 10, 1948, to May 11, 1948

and that I last saw him alive on May 10, 1948

Immediate cause of death

Cerebral Hemorrhage

DURATION

6 hours.

Due to My pectoralis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address 501 Pershing St Date signed 5/11/48

RECEIVED
MAY 18 1948
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04548

6

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

Allegany
County.....Dansville Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution? - - - - -

3. (a) FULL NAME

Mrs. Carrie (John) Lancaster

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

female white married

6. (b) Name of husband or wife John Lancaster

7. Birth date of deceased (mo., day, yr.)

March 30-1894

6. (c) If alive, give age 50 years

8. AGE: Years

Months

Days

If less than one day

54 1 26 hrs. min.

9. Birthplace Barton Md. Allegany, Md.
(Town, county, and state)

10. Usual occupation housewife

11. Industry or business own home

12. Name Lee Ross

13. Birthplace Barton Md.

14. Maiden name Ester Klipstein

15. Birthplace Barton Md.

16. Informant John Lancaster

Address Dansville Md.

17. Burial Date thereof May 30, 1948
(Burial, cremation, or removal. Which?)

Cemetery or crematory Waxler Cemetery

Location Danville, Md.

18. Funeral director Ellsworth S. Boal

Address Westernport, Md.

19. May 20, 1948, registered by me
(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Dansville
(If outside city or town limits, write RURAL and give nearest town)Street No. - - - - -
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION about

20. DATE OF DEATH May 26 1948, 21st 2 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw her alive May 26 1948, to 1948.

Immediate cause of death

Chronic myocarditis

DURATION

10 yrs.

Due to

Due to

Other conditions Hypertension

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

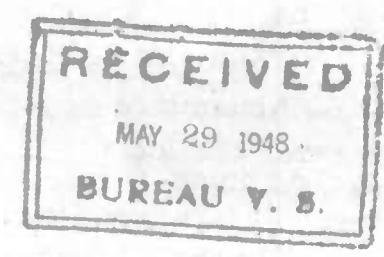
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Deputy Medical Examiner - Allegany Co. Injured at work?

23. SIGNATURE H. V. Deming M.D. H. V. Deming M.D. M. D. or

Address Cumberland Md. Date signed 5-26-48



Within corporate limits

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04549

97

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH:

Allegany

County

Cumberland

City or town

(If outside city or town limits, write RURAL and give nearest town)

28 years

How long in above place of death?

Hospital, institution, or street address where death occurred:

131 Cumberland Street

How long in hospital or institution?

3. (a) FULL NAME

AMBROSE LAWRENCE

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

Mary A. (Harper) Lawrence

6.(c) If alive, give age 79 years

7. Birth date of deceased (mo. day. yr.)

February 13, 1862

8. AGE:

Years
86Months
3Days
18

If less than one day

hrs. min.

9. Birthplace

Riverton, Pendleton, West Virginia

(Town, county, and state)

10. Usual occupation

Conductor (Retired)

11. Industry or business

W.M. Railroad

MOTHER FATHER

Joshua Lawrence

12. Name

13. Birthplace

Pendleton Co. W. Va.

14. Maiden name

Katherine Phares

15. Birthplace

Pendleton Co. W. Va.

16. Informant

Mrs. Nela G. Wood

Address 131 Cumberland St, Cumberland, Md.

17. Burial

Date thereof June 2, 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory Hill Crest Burial Park

Location Cumberland, Maryland

18. Funeral director

William H. Kight

Address Cumberland, Md.

19. Date rec'd by registrar

19. 48

W.H. Kight, M.D.
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 131 Cumberland Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 30

1948 at

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 10

1948 to May 30

1948

and that I last saw him alive on May 30

1948

Immediate cause of death

Anterior clausis

Due to

Decility

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W.H. Kight, M.D.

M. D. or other

Address 49 Green St Date signed 6-2-48



X-46-5

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04550

DR. HAWKINS

462

Reg. Dist. No.

4

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
County ALLEGANY

City or town CUMBERLAND MARYLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 19 DAYS & 4 HOURS

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution? 19 DAYS & 4 HOURS

3. (a) FULL NAME

MRS. IDA LEE

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6. (b) Name of husband or wife ROBERT H. LEE

RT# DEER PARK, MD 6. (c) If alive, give age 61 years
7. Birth date of deceased (mo., day, yr.) OCTOBER 30, 1889

8. AGE: Years 58 Months 1 Days 1 If less than one day hrs. min.

9. Birthplace PENNA (Town, county, and state)

10. Usual occupation WIFE

11. Industry or business

MOTHER FATHER 12. Name JEREMIAH UPHOLD

13. Birthplace Unknown

14. Maiden name LUCY COLENS

15. Birthplace Pennsylvania

16. Informant Memorial Hospital

Address Cumberland, Md.

17. Burial Date thereof May 4, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Pleasant Valley Cemetery

Location Garrison Co., Md.

18. Funeral director Herbert C. Keighon

Address Oakland, Md.

19. May 3, 1948 W.H. Hawks, M.D.
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County GARRETT

City or town DEER PARK (If outside city or town limits, write RURAL and give nearest town)

Street No. RT# 2 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH May 1, 1948 at 4:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from after 12 1948, to May 1, 1948 and that I last saw her alive on May 1, 1948.

Immediate cause of death Ostalgia
Parsinoma sigmoid colon
Cecostomy
Due to:

Hemoba Phlebitis veins
of leg
operation removed

Other conditions Surf of Colon
(Include pregnancy within 3 months of death)

Major findings of operations Obtunty Cancerous sigmoid
Date of op. Apr. 27, 1948

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE D.H. Hawkins M. D. or other

Address Circleville, Md. Date signed May 1, 1948

RECEIVED

MAY 11 1948

BUREAU V. S.

Within corporate limits
With correct
name and
legible.

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Try to correct
any mistake or omission. Physicians: please write the causes of death clearly and legibly.

Bailey Hunter

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

04551

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 26 years

Hospital, Institution, or street address where death occurred:

706 Lafayette Ave.

How long in hospital or institution?

3. (a) FULL NAME

Mary Rhodes Logsdon

4. Sex

F

5. Color or race

W

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife

John Logsdon

7. Birth date of deceased (mo., day, yr.)

May 23, 1861

(6.c) If alive, give age years

8. AGE:

Years 86

Months 11

Days 11

If less than one day

hrs.

min.

9. Birthplace

Spring Gap, Md.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Own home

MOTHER FATHER

12. Name

Leonard Huff

13. Birthplace

Maryland

14. Maiden name

Elizabeth Davis

15. Birthplace

Spring Gap, Md.

16. Informant

Mrs. Mary Huff

Address

424 Goethe St., Cumberland, Md.

17. Burial!

Burial

Date thereof

May 6, 1948

(month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Hillcrest Cemetery

Location

Cumberland, Md.

18. Funeral director

John J. Hough

Address

Cumberland, Md.

19. Date rec'd by registrar

May 6, 1948

Wh. County, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md

County

Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 706 Lafayette Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

2D. DATE OF DEATH

May 4

1948

at 1:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 1948, to May 4, 1948,

and that I last saw her alive on May 3, 1948.

Immediate cause of death

Cardio-renal disease

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

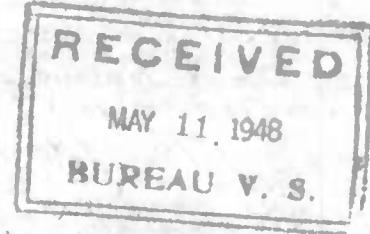
Means of injury

Injured at work?

23. SIGNATURE

T. Bailey Hunter M. D. or other

Address: Cumberland, Md. Date signed: 5/4/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04552

61

4

CERTIFICATE OF DEATH

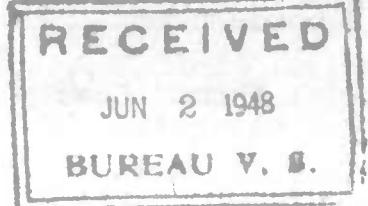
Reg. Dist. No.....

1. PLACE OF DEATH:
County Allegany
City or town Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 35 years
Hospital, Institution, or street address where death occurred:
421 Independence St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 421 Independence St.
(If rural, give LOCATION)

3. (a) FULL NAME
Anna Viola Lowery
4. Sex female 5. Color or race white 6.(a) Single, married, widowed, or divorced divorced
6.(b) Name of husband or wife Robert Creighton
7. Birth date of deceased (mo., day, yr.) Oct. 4- 1892
6.(c) If alive, give age years
8. AGE: Years 55 Months 7 Days 19 It less than one day hrs. min.
9. Birthplace Ellerslie Md. Allegany, Maryland
(Town, county, and state)
10. Usual occupation housekeeper
11. Industry or business
MOTHER FATHER
12. Name Samuel Thomas Lowery
13. Birthplace Ellerslie Md.
MOTHER FATHER
14. Maiden name Alcinda Yost
15. Birthplace Ellerslie, Md.
16. Informant Mrs. Harry Gilpin,
Address Cumberland, Md.
17. Burial Date thereof May 27, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory St. Lukes Cemetery
Location Cumberland, Maryland
18. Funeral director William H. Kight
Address Cumberland, Md.
19. May 26, 1948 W. J. Daugherty M.D.
(Date rec'd by registrar) Registrar

3. (b) Social Security Number None
MEDICAL CERTIFICATION about
2D. DATE OF DEATH May 23 19 48, at 3 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
19. , to .
and that I last saw her alive Dead May 24 19 48.
Immediate cause of death Coronary occlusion
DURATION at once
Due to Coronary sclerosis about 1 yr.
Due to Diabetic.
(Include pregnancy within 3 months of death)
Other conditions Diabetic.
Major findings of operations Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury Injured at work?
Deputy Medical Examiner - Allegany Co
23. SIGNATURE H. V. Deming M.D. H. V. Deming M.D.
M. D. or other 5-24-48
Address Cumberland Md. Date signed 5-24-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04553
94a

CERTIFICATE OF DEATH

Reg. Dist. No. /

1. PLACE OF DEATH:

County Allegany

City or town Rural) near Picardy Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? about 1 week

Hospital, institution, or street address where death occurred:

house on Miller Farm, near route 51

How long in hospital or institution?

3. (a) FULL NAME

Jess McKenzie

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
male	white	Cora Nelson divorced

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo. day, yr.) Feb. 29-1884

8. AGE: Years	Months	Days	If less than one day
64	2	27	hrs. min.

9. Birthplace Mineral Co. W.Va.
(Town, county, and state)

10. Usual occupation Laborer B & O.R.Ry.

11. Industry or business

12. Name Mose McKenzie

13. Birthplace Mineral Co. W.Va.

14. Maiden name Mary M. Lark

15. Birthplace Mineral Co. W.Va

16. Informant Mrs. Harry Butts

Address 443 Pennsylvania Ave.

17. Burial Date thereof May 29, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Greenmount Cem.

Location Cumberland, Md.

18. Funeral director James F. Scarpelli

Address Cumberland, Md.

19. Date rec'd by registrar May 28 1948 Mrs A. Shambolt

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Rural) near Picardy Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. P.O.R.F.D.1 Paw Paw W.Va.

(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (b) Social Security Number

MEDICAL CERTIFICATION

about
20. DATE OF DEATH May 26 1948 at 10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw h. im all. to. 19. 48.

Immediate cause of death

Coronary occlusion

DURATION
at once 2

Due to Coronary sclerosis

about 2
years

Due to

Other conditions hypertension

(Include pregnancy within 3 months of death)

Major findings at operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

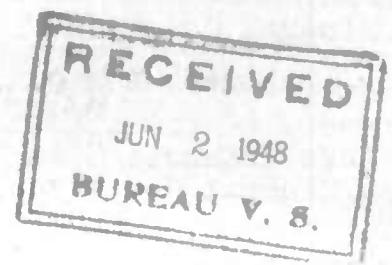
Means of injury

Injured at work?

Deputy Medical Examiner Allegany Co.
23. SIGNATURE H.A.V. Deming M.D. H.A.V. Deming M.D.
M.D. or other

Address Cumberland Md.

Date signed 5-27-48



Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04554

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County alleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 19 days

Hospital, institution, or street address where death occurred:

allegany county flameHow long in hospital or institution? 19 days

3. (a) FULL NAME

Mollie M. Lartie

4. Sex

Female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Henry M. Lartie6. (c) If alive, give age 90 years

7. Birth date of deceased (mo., day, yr.)

Jan, 11th 1864

8. AGE:

Years	Months	Days	If less than one day
84	3	24	hrs. min.

9. Birthplace

Lancaster allegany, md
(Town, county, and state)

10. Usual occupation

House works

11. Industry or business

Own Home

12. Name

Father

13. Birthplace

wales

14. Maiden name

Mary E. Ferment

15. Birthplace

England

16. Informant

Henry M. Lartie

Address

Lancaster, md

17. Burial

Date thereof May 8, 1948
(month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory Oaks Hill Cemetery

Location

Lancaster, md

18. Funeral director

M. Eichhorn

Address

Lancaster, md

19. Date rec'd by registrar

May 8, 1948

W.H. Raub, M.D.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County alleganyCity or town Lancaster
(If outside city or town limits, write RURAL and give nearest town)Street No. East main st
(If rural, give LOCATION)2.(a) If veteran, name war L

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5 1948 at 11³⁰ A.M.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from

Apr 6 1948 to May 5 1948
and that I last saw her alive on Apr 30 1948

Immediate cause of death

Myocardial failure
Due to Chronic MyocarditisDue to Tenacity

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Arthur J. Jones M.D.
M. D. or other
Address 110 S. Centre St. Date signed 5-5-48

RECEIVED

MAY 11 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04555

83a

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

ALLEGANY

County.....

CUMBERLAND, MARYLAND

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 DAYS

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution? 2 DAYS

3. (a) FULL NAME

MINKE, MARY GERTRUDE MRS.

4. Sex

FEMALE

5. Color or race

WHITE

6. (or single, married, widowed, or divorced)

Divorced

6.(b) Name of husband or wife

John E. Hocking (deceased)

7. Birth date of deceased (mo. day, yr.)

February 2 1899

6.(c) If alive, give age years

8. AGE:

Years
49Months
3Days
1

If less than one day

hrs.

min.

9. Birthplace

MD. Cumberland

(Town, county, and state)

10. Usual occupation

HWFEE

11. Industry or business

HOME

MOTHER FATHER

12. Name MINKE, JOHN J.

13. Birthplace

MARYLAND

14. Maiden name

ROBINSON, AGNES CATHERINE

15. Birthplace

MARYLAND

16. Informant

John E. Hocking
322 Davidson St, Cumberland, Md.

17. Burial

(Burial, cremation, or removal. Which?) Date the May 7 1948
(month) (day) (year)

Cemetery or crematory St Peter & Paul Cemetery

Location

Cumberland, Md.

18. Funeral director

William H. Kight
Cumberland, Md.

Address

Cumberland, Md.

May 6 1948

(Date rec'd by registrar)

W.R. Trautz, M.D.
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

MARYLAND

County ALLEGANY

City or town

CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

Street No. 216 BEALL ST.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

MAY 3, 1948

20. DATE OF DEATH MAY 3, 1948

I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 1 to May 3, 1948, and that I last saw him alive on May 3, 1948.

Immediate cause of death

Cerebral Hemorrhage

DURATION

5 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, tell in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

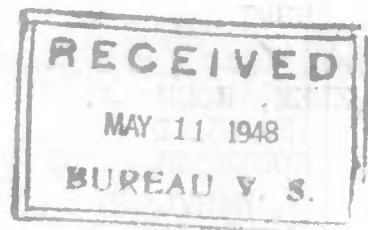
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W.R. Trautz, M.D. Date signed 5/4/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04556

83a

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County

Allegany

Cumberland

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

535 Columbia Ave.

How long in hospital or institution?

3. (a) FULL NAME

John Morrissey

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

(Unknown) 1873

6. (c) If alive, give age..... years

8. AGE:

Years
75

Months

Days

Less than one day

hrs. min.

9. Birthplace

Cumberland, Maryland

(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

Celanese Corp. of America

MOTHER FATHER

12. Name

Michael Morrissey

13. Birthplace

Ireland

14. Maiden name

Margaret Morrissey

15. Birthplace

Penns.

16. Informant

Louis Stein, Jr.

Address

Cumberland, Md.

17. Burial

Date thereof May 12, 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Saint Patrick's Cem.

Location

Cumberland, Md.

18. Funeral director

Louis Stein, Jr.

Address

Cumberland, Maryland

19. Date rec'd by registrar

May 11, 1948

W. Frank M.D.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

Allegany

City or town

Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 535

Columbia Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

214-07-5122

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 9,

1948 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from

May 7, 1948, to

and that I last saw him alive on May 8

1948

Immediate cause of death

Cerebral hemorrhage

DURATION

2 days

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

R. A. Treaske, M.D.

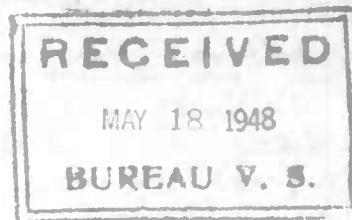
M. D. or other

Address

Cumberland, Md.

Date signed

May 10, 1948



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04557

518

Reg. Dist. No. 4

CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. Use correct age
is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County ALEEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 DAYS

Hospital, Institution, or street address where death occurred: MEMORIAL HOSPITAL

How long in hospital or institution? 3 DAYS

3. (a) FULL NAME

ELIJAH FRANKLIN NELSON

4. Sex MALE	5. Color or race WHITE	6.(a) Single, married, widowed, or divorced MARRIED
-------------	------------------------	---

6.(b) Name of husband or wife BERTIE MALLOW

7. Birth date of deceased (mo., day, yr.) FEB 17, 1880 1881
6.(c) If alive, give age 58 years

8. AGE: Years 67	Months 3	Days 12	If less than one day hrs. min.
------------------	----------	---------	--------------------------------

9. Birthplace W. VA
(Town, county, and state)

10. Usual occupation FARMER

11. Industry or business

MOTHER FATHER 12. Name ELIJAH NELSON

13. Birthplace W. VA

MOTHER 14. Maiden name ELIZABETH THOMPSON

15. Birthplace W. VA

16. Informant MEMORIAL HOSPITAL

Address MEMORIAL AVENUE

Burial 17. Burial Date thereof May 31, 1948

(Burial, cremation, or removal? Which?) Glendale Brothers Cem

Cemetery or crematory

Location 18. Location near Baltimore, Md.

Funeral director 19. Funeral director Joe P. Ballantine

Address Everett, Penna.

Date rec'd by registrar May 31, 1948

W.L. Trout, M.A. Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State PENN County BEDFORD

City or town EVERETT PA
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (b) Social Security Number

Noel

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 29 1948 at 6:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

26 May 1948 to May 29 1948

and that I last saw him alive on May 29 1948

Immediate cause of death

Cerebral Hemorrhage

To bladder

Due to Hydrocephalus

Due to Hydrocephalus

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

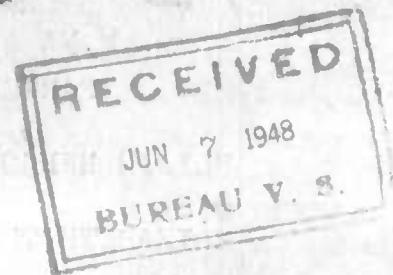
Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Reg. M. Jones M. D. or other

Address Memorial Hospital Date signed May 29, 1948



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

96

04558

CERTIFICATE OF DEATH

Reg. Dist. No. 4

M
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age
is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County..... Allegany
City or town..... Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Memorial Hospital, Cumberland Md.

Now long in hospital or institution? about 1.3/4 hours

3. (a) FULL NAME

William C. Nelson

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

male white married

6.(b) Name of husband or wife Rozella Petenbrink

7. Birth date of deceased (mo., day, yr.) May 10-1924

6.(c) If alive, give age 22 years

8. AGE: Years Months Days If less than one day

24 0 2 hrs. min.

9. Birthplace Randolph Co. W.Va.

(Town, county, and state)

10. Usual occupation laborer

11. Industry or business Construction work

MOTHER FATHER 12. Name William Nelson (Foster) father

13. Birthplace W. Va.

14. Maiden name Ann Phares

15. Birthplace W. Va.

16. Informant Mrs. Rozella Nelson

Address 324 N. Mechanic ST, Cumberland, Md.

17. Burial Date thereof 5/15/48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Greenmount Cem.

Location Cumberland, Md.

18. Funeral director H. Wayne George

Address Cumberland, Md.

19. May 15, 1948. Wd. Drayz, M.D.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 324 N. Mechanic St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

234 - 30 - 1956

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12 1948, at 3.20 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

19. to 19.

and that I last saw him alive Dead May 12 1948

Immediate cause of death

Intracranial hemorrhage due to
a rupture of a cerebralabout
*Note: aneurysm, anterior to the circle of Willis. 2 hours

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

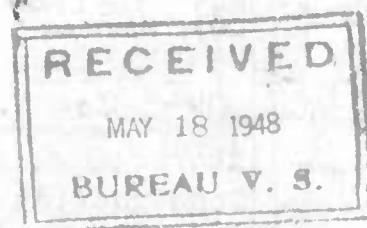
Means of injury Injured at work?

Deputy Medical Examiner - Allegany

23. SIGNATURE H. V. Deming M.D. H. V. Deming M.D.

M. D. or

Address Cumberland Md. Date signed 5.13-48



Within corporate limits

MARGIN RESERVED FOR BINDING

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

95c

04559

4

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County..... Allegany County Memorial Hospital

City or town..... Cumberland, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Memorial Hospital

How long in hospital or institution?

15 Hrs.

3. (a) FULL NAME

JOSEPH H. NEWHOUSE

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife.....

Isabel Davis

6.(c) If alive, give age..... 78 years

7. Birth date of deceased (mo. day yr.)

June 30, 1864

Years

83

Months

10

Days

13

If less than one day

hrs.

min.

9. Birthplace.....

West Virginia

(Town, county, and state)

10. Usual occupation.....

Mechanic

11. Industry or business.....

Own business

MOTHER FATHER

12. Name..... Newhouse

13. Birthplace..... W. Va.

14. Maiden name.....

Rebecca Jane Earle

15. Birthplace.....

Ireland

16. Informant.....

Mrs Myrtle Tallant

Address.....

Romney, W. Va.

17. Burial, cremation, or removal. Which?)

Date thereof May 15, 1948
(month) (day) (year)

Cemetery or crematory.....

Julin Moore Cemetery

Location.....

Romney, W. Va.

18. Funeral director.....

Mervil H. Conk

Address.....

Romney, W. Va.

19. Date rec'd by registrar.....

May 13, 1948 Walter G. Gray, M.D.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... W. Va. County..... HAMPSHIRE

City or town..... Romney, W. Va.

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 13, 1948, at 7:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw h. im a DEAD May 13, 1948.

Immediate cause of death..... CARDIAC FAILURE
DUE TO CORONARY SCLEROSIS, CARDIAC
HYPERSTROPHY AND PROSTATIC hypertrophy yrs.

Due to.....

Due to.....

Other conditions..... DISTENTION OF BLADDER

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

Deputy Medical Examiner = Allegany Co.

23. SIGNATURE.....

G. V. Denning M.D.

M. D. or other

Address..... Cumberland, Md. Date signed..... May 13, 1948

RECEIVED

MAY 18 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

195d

0-560
6

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County..... *Allegany*City or town..... *Waterupert - rural*

(If outside city or town limits, write RURAL and give nearest town)

Towmks

How long in above place of death?.....

Hospital, institution, or street address where death occurred:

R.F.D. #1 Bay 9

How long in hospital or institution?.....

8

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland* County *Allegany*City or town..... *Waterupert - rural*

(If outside city or town limits, write RURAL and give nearest town)

Street No. *RFD #1 - Bay 9*

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

4. Sex <i>Male</i>	5. Color or race <i>white</i>	6.(a) Single, married, widowed, or divorced <i>Single</i>
--------------------	-------------------------------	---

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) *April 9, 1848*

6.(c) If alive, give age years

8. AGE: Years *0* Months *1* Days *19* If less than one day — hrs. — min.9. Birthplace *Waterupert, Allegany, Maryland*
(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

12. Name *John James Patterson*13. Birthplace *Waterupert, Md*14. Maiden name *Eadlyn Louise Lambert*15. Birthplace *Waterupert, Md*16. Informant *John J. Patterson*Address *Waterupert, Md*17. Burial *Burial*

(Burial, cremation, or removal. Which?)

Date thereof *May 30, 1948*
(month) (day) (year)Cemetery or crematory *Phelan Cemetery*Location *Waterupert, Md*18. Funeral director *Edward S. Boal*Address *Waterupert, Md.*19. *May 28, 1948*
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *May 28, 1948*, at *1 A.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw her *dead* May 28, 1948

Immediate cause of death.....

*Aphyseptism*Due to *Aspiration of stomach contents*

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

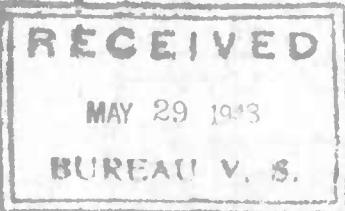
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury *Deputy Medical Examiner - Allegany Co* Injured at work?23. SIGNATURE *R.V. Brining M.D.*

M. D. or other

Address *Cumberland, Md.* Date signed *5-28-48*



Within corporate limits

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

61

04561

4

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County..... Allegany

City or town..... Cumberland Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred

1105 Lexington Avenue

How long in hospital or institution?

3. (a) FULL NAME

Jennie Virginia Payton

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

white

widow

6. (b) Name of husband or wife

Robert Payton

6. (c) If alive, give age * years

7. Birth date of deceased (mo. day yr.)

March 19-1884

8. AGE:

Years
64Months
1Days
28

If less than one day

hrs.

min.

9. Birthplace

21st. Bridge Md.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

12. Name

George Washington House

13. Birthplace

Frederick Md.

MOTHER FATHER

14. Maiden name

Susan M. Dayton

15. Birthplace

21st. Bridge Md.

16. Informant

Mrs. Emma Hinrichs (sister)

Address

Mc Coole Md.

17. Buried

Date thereof May 19 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Dawson Cem.

Location

Dawson, Md.

18. Funeral director

Charles L. George

Address

Cumberland, Md.

May 18 1948

(Date rec'd by registrar)

W.L. Tracy M.D.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md.

County..... Allegany

City or town..... Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 1105 Lexington Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION about

20. DATE OF DEATH May 17

19 48, at 4 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... to ... 19...

and that I last saw h. & R. Dead May 17 19 48.

Immediate cause of death

Uremia

DURATION

Due to Diabetes Mellitus

several years

Due to

Other conditions Partial paralysis of the bowels following operation

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

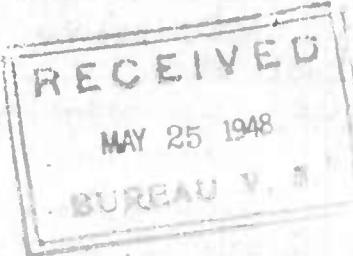
Deputy Medical Examiner - Allegany Co.

23. SIGNATURE H.V. Deming M.D.

H.V. Deming M.D.

M. D. or other

Address Cumberland Md. Date signed 5-17-48



Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04562

CERTIFICATE OF DEATH

Reg. Dist. No. 4

The correct age
is especially important.

1. PLACE OF DEATH:

County

allegany

City or town

Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

20 yrs.

Hospital, institution, or street address where death occurred:

612 Washington

How long in hospital or institution?

3. (a) FULL NAME

Nancy Allen Poling

4. Sex

Female

5. Color or race

White

6. Extra: Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Samuel C. Poling

7. Birth date of deceased (mo., day, yr.)

Feb. 9, 1873

8. AGE:

Years

Months

Days

If less than one day

75

2

35

hrs.

min.

9. Birthplace

(Town, county, and state)

Tucker Co. West Va.

10. Usual occupation

Housewife

11. Industry or business

MOTHER FATHER

Name

Francis G. Poling

Birthplace

West Va.

Maiden name

Lizzie

Birthplace

West Va.

Name

Carrie B. Poling

Address

Cumberland Md.

Burial

Parson

Date thereof

5/6/1948

(Burial, cremation, or removal. Which?)

(month)

(day)

(year)

Cemetery or crematory

Parson

W. Va.

Location

Parson

Name

Louis Stein Jr.

Funeral director

Cumberland Md.

Address

Cumberland

Md.

Date rec'd by registrar

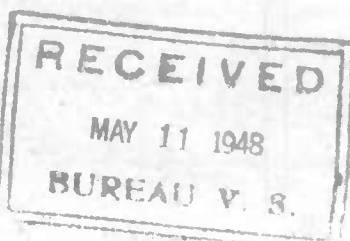
May 6, 1948

M.D. or other

W. H. Trautz, M.D.

Registrar

VS A15 9-45-15M



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04563

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County

Allegany
Eckhart Mines

City or town.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Margret Catherine Porter

4. Sex

F

5. Color or race

W

(a) Single, married, widowed, or divorced

widowed

6. (b) Name of husband or wife

Charles W. Porter

7. Birth date of deceased (mo., day, yr.)

April 10, 1861

(c) If alive, give age..... years

8. AGE:

Years
87Months
10Days
25If less than one day
hrs. min.

9. Birthplace

Wellersburg, Somerset, Pa.

(Town, county, and state)*

10. Usual occupation

Housewife

11. Industry or business

Home

John Beal

12. Name

John Beal

13. Birthplace

Wellersburg, Pa.

14. Maiden name

Lydia Embrich

15. Birthplace

Wellersburg, Pa.

16. Informant

Thomas Porter

Address

Eckhart, Md.

17. Burial

Date thereof May 9, 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Eckhart Cemetery

Location

Eckhart, Md.

18. Funeral director

J. R. Luerst

Address

Frostburg, Md.

19. S-9

(Date rec'd by registrar)

19.

48 Mrs. Henry N. Roe

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Allegany

City or town

Eckhart Mines

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 6 1948 at 2:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1948 to 1948, and that I last saw her alive on May 31, 1948.

Immediate cause of death

Chronic Cardiac Disease

DURATION

Due to

Sensitization

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

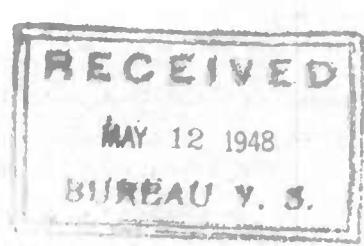
Injured at work?

23. SIGNATURE

Wm. J. Roe

M. D. or other

Frostburg, Md. Date signed 5-7-48



M
■ PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

R. Schindler
04564

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County

Allegany

City or town

Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs.

Hospital, Institution, or street address where death occurred:

Offutt Street

How long in hospital or institution?

3. (a) FULL NAME

James F. Rankin

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Bessie Robinette

7. Birth date of deceased (mo., day, yr.)

September 24, 1889

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Martinsburg, W. Va.

(Town, county, and state)

10. Usual occupation

Car repairman

B & O. R.R.

11. Industry or business

MOTHER FATHER

John Rankin

12. Name

W. Va.

13. Birthplace

W. Va.

14. Maiden name

Anna Litter

15. Birthplace

W. Va.

16. Informant

Bessie Rankin

Address

1318 Virginia Ave., Cumberland, Md.

17. Burial

Date thereof

May 29, 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Rose Hill Cemetery

Location

Cumberland, Md.

18. Funeral director

Davis & Son, Inc.

Address

Cumberland, Md.

19. Date rec'd by registrar

May 28, 1948

W. H. Daub, M.D.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. Offutt Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

705-09-5239

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 27, 1948 at 1:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 1, 1948, to May 27, 1948,

and that I last saw him alive on May 23, 1948.

Immediate cause of death

Coronary Disease

Due to

Hypertension C.V. Disease

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

R. M. Schindler

M.D. or other

Address

44 Ernest

Date signed

May 27, 1948

RECEIVED

JUN 2 1948

BUREAU V. S.

Within corporate limits

M
Age

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04565

95b
4

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

1015 Virginia Ave.

How long in hospital or institution?

3. (a) FULL NAME

4. Sex Male 5. Color or race white 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Naomi Silvious

7. Birth date of deceased (mo., day, yr.) May 28 1912 6. (c) If alive, give age 34 years

8. AGE: Years 35 Months 11 Days 5 If less than one day hrs. min.

9. Birthplace Cumberland Allegany Co Md
(Town, county, and state)

10. Usual occupation Machinist

11. Industry or business Calanese Corp.

MOTHER FATHER
12. Name Glennie W. Rankin

13. Birthplace Sleepy Creek W. Va.

14. Maiden name Mary C. Furlow

15. Birthplace Tidington Md.

16. Informant John D. Rankin

Address 237 Everett Ave - Cumberland

17. Burial Date thereof May 6, 1948
(Burial, cremation, or removal. Which?)
(month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Cumberland Md.

18. Funeral director John J. Hafer

Address Cumberland Md.

19. Date rec'd by registrar May 6, 1948

(Date rec'd by registrar) W. L. Puckett M.D.

Registrar May 6, 1948

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1015 Virginia Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

214-07-6741

MEDICAL CERTIFICATION

20. DATE OF DEATH May 3 1948 at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 10 1948 to May 3 1948

and that I last saw him alive on May 2 1948

Immediate cause of death

Obstructive heart disease DURATION Years

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

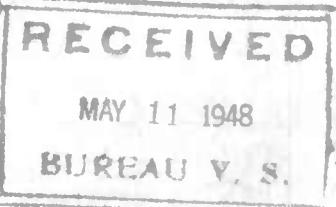
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE B. M. Schneider M.D. M. D. or other

Address 41 Street Date signed May 5/1948



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Dr Reeves 04566

838

Reg. Dist. No. 6

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County Allegany

City or town Westernport

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 34 years

Hospital, Institution, or street address where death occurred:

270 Main St.

How long in hospital or institution?

3. (a) FULL NAME

JOSEPH PEARCE REED

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widower

6. (b) Name of husband or wife

Mary Ellen Wilt Reed

7. Birth date of deceased (mo. day. yr.)

October 11, 1863

6. (c) If alive, give age - - - years

8. AGE:

Years
84Months
6Days
27

If less than one day

hrs.

min.

9. Birthplace

Elk Garden, Mineral, W. Va.

(Town, county, and state)

10. Usual occupation

Carpenter (retired)

11. Industry or business

Building

MOTHER FATHER

12. Name Alexander Reed

13. Birthplace W. a.

14. Maiden name Sarah O'Haver

15. Birthplace W. Va.

16. Informant

W. B. Reed

Address

Westernport, Md.

17. Burial

Date thereof May 11, 1948

(Burial, cremation, or removal. Which?)

Cemetery or crematory Bloomington Cemetery

Location

Bloomington, Md.

18. Funeral director

Ellsworth S. Boal

Address

Westernport, Maryland

19. Date record by registrar

May 11 1948

Signature of Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Allegany

City or town EXXXXXXX Westernport

Street No. 270 Main St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 8

1948 at 11:15 p

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 1 1948 to May 8 1948

and that I last saw him alive on May 8 1948

Immediate cause of death

Artus occlusio
Central Thrombosis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

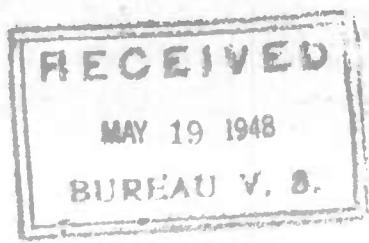
Injured at work?

23. SIGNATURE

Norman Reed, M.D.

M. D. or other

Address Westernport, Md. Date signed 5/10/48



~~in corporate limit.~~
*Alan E. Grawash
Revocable*

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04567

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 years

Hospital, Institution, or street address where death occurred:

225 Baltimore Ave.

How long in hospital or institution?

3. (a) FULL NAME

Mrs. Mary Cheney Robinette

4. Sex

F

5. Color or race

W

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife Jasper W. Robinette

7. Birth date of deceased (mo. day yr.) September 9, 1857

6.(c) If alive, give age years

8. AGE: Years Months Days It less than one day

90 8 16 hrs. min.

9. Birthplace Murley's Branch, Allegany, Md.

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own house

12. Name Isaac Cheney

13. Birthplace Murley's Branch

14. Maiden name Henrietta Roberts

15. Birthplace Allegany Co.

16. Informant Mrs. Harriet D. White

Address 225 Baltimore Ave, Cumberland, Md.

Date thereof May 27, 1948

(month) (day) (year)

17. Burial Cemetery Hillcrest Cemetery

Location Cumberland, Md.

18. Funeral director John J. Hayes

Address Copefield Chapel, Cumberland

May 27, 1948 Cert. Frank, M.D.

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 225 Baltimore Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH May 25, 1948, at 10:00 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 25 to May 26, 1948.

and that I last saw her alive on May 25, 1948.

Immediate cause of death Cardiac Failure

DURATION 2 months

Due to Senility

Due to Chronic Myocarditis

6/28/48 OS

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

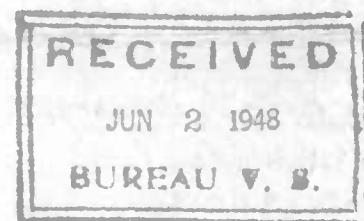
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Alan E. Grawash, M.D.

Cumberland M.D. or other

Address 225 Baltimore Ave. Date signed May 25, 1948



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Dr A Jones

04568

93d

Reg. Dist. No.

4

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County

Allegheny

Cumberland

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

3 years

Hospital, institution, or street address where death occurred:

Allegheny County Infirmary

How long in hospital or institution?

3 yrs

3. (a) FULL NAME

Mary Ruppert

4. Sex

F.

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Jacob Ruppert

6. (c) If alive, give age..... years

7. Birth date of

deceased (mo., day, yr.)

March 19, 1862

8. AGE: Years

86

Months

1

Days

12

If less than one day

hrs.

min.

9. Birthplace

Cumberland Maryland

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

MOTHER FATHER

Henry Gendeman

12. Name

Mrs.

13. Birthplace

Md.

MOTHER FATHER

Elizabeth Schellhouse

14. Maiden name

Md.

15. Birthplace

Md.

MOTHER FATHER

Richard Ruppert

16. Informant

Ridgely, W. Va.

Address

MOTHER FATHER

Ridgely, W. Va.

MOTHER FATHER

Burial

MOTHER FATHER

Date thereof

MOTHER FATHER

May 5, 1948

MOTHER FATHER

(Burial, cremation, or removal. Which?)

MOTHER FATHER

St. Peter's & Paul's Cemetery

MOTHER FATHER

Cumberland, Md.

MOTHER FATHER

Location

MOTHER FATHER

Louis Stein, Inc.

MOTHER FATHER

Address

MOTHER FATHER

Cumberland, Maryland

MOTHER FATHER

Date rec'd by registrar

MOTHER FATHER

May 4, 1948

MOTHER FATHER

Dr. Frank M. D.

MOTHER FATHER

Registrar

MOTHER FATHER

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Allegheny

City or town

Mt. Mechanic, Cumberland

Street No.

Mt. Mechanic St

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

Stone

MEDICAL CERTIFICATION

2D. DATE OF DEATH

May 1,

1948

at 5:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dre

1948, to

May 1, 1948

and that I last saw her alive on

Apr 30

1948

Immediate cause of death

Myocardial failure

DURATION

9 days

Due to

Chronic Myocarditis

4 yrs

Due to

Senility

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

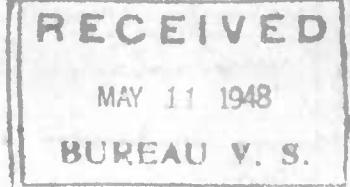
Arthur F. Jones M.D.

M. D. or other

Address

110 S. Centre St.

Date signed 5-3-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04569

170C

5-

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County..... Allegany
City or town..... near Cumberland Md. (Amcelle)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... at once

Hospital, Institution, or street address where death occurred:

Route 220 onroad in front of main gate at Celanese Corp. of Am.

How long in hospital or institution?.....

3. (a) FULL NAME

Friend
Mrs. Hazel Russ

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female White Widow

6. (b) Name of husband or wife

Walter Russ

7. Birth date of deceased (mo. day, yr.)

Jan. 27-1911

6. (c) If alive, give age..... years

8. AGE:

Years Months Days It less than one day
37 3 6 hrs. min.

9. Birthplace

Oakland Maryland
(Town, county and state)

10. Usual occupation

Celanese Corp. of Am.

11. Industry or business

Rayon

MOTHER FATHER

12. Name..... Le Roy Friend

13. Birthplace..... Maryland

14. Maiden name..... Zeltha Knox

15. Birthplace..... Maryland

16. Informant..... Louis Stein, Inc.

Address..... Cumberland, Md.

17. Burial

(Burial, cremation, or removal, Which?)

Date thereof..... May 5, 1948
(month) (day) (year)

Cemetery or crematory..... Hillcrest Burial Park

Location.....

Cumberland Maryland

18. Funeral director..... Louis Stein, Inc.

Address.....

Cumberland, Maryland

19. Date rec'd by registrar..... May 4, 1948

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md. County..... Allegany

City or town..... Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No..... 529 Green St.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

220-03- 7622

MEDICAL CERTIFICATION

about A

20. DATE OF DEATH..... May 3, 1948, at 10.15 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to. 19.

and that I last saw her alive Dead May 3, 1948.

Immediate cause of death

Subdural hemorrhage & shock

DURATION

at once

Due to hit by an Automobile

Walked in front of bus in path

Due to of auto. going south.

Other conditions Fractured left leg above ankle
fracture at right wrist also 6, 7, 8 rib
in right nipple line.
(Indicate all fractures within 12 hours of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide or homicide Auto. accident Date of 5-3-48

Route 220 Amcelle

Where did injury occur near Cumberland Allegany Md.

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Highway, as above

Means of injury hit by auto.

Injured at work going to

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE..... H. V. Deming M.D. 44 W. Drury St. M.D.

M. D. or other

Address..... Cumberland Md.

Date signed 5-3-48

RECEIVED

MAY 8 1948

BUREAU V. S.

Within corporate limits

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159

04579

4

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County

Allegany

City or town

Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

allegany Hospital

How long in hospital or institution?

3. (a) FULL NAME

Baby Girl Schriver

4. Sex

F

5. Color or race

W

6.(a) Single, married, widowed, or divorced

S

6.(b) Name of husband or wife

7. Birth date of deceased (mo. day, yr.)

May 20, 1948

6.(c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

2 hrs.

min.

9. Birthplace

Cumberland, Allegany, Maryland

(Town, county, and State)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

Ceil Schriver

13. Birthplace

Cumberland Md

14. Maiden name

Mary Martin

15. Birthplace

Md.

16. Informant

Ceil Schriver

Address

513 Dilley St, Cumberland Md

17. Burial

Date thereof

May 21, 1948
(month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory

St. Peter's & Paul's Cem.

Location

Cumberland Md.

18. Funeral director

Loris Stein Jne

Address

Cumberland Md.

19. Date rec'd by registrar

May 21, 1948

(Date rec'd by registrar)

V. D. Drury, M.D.
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md.

County

Allegany

City or town

Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No.

513

Dilley St

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 20, 1948 at 10:16 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 20, 1948 to May 20, 1948

and that I last saw her alive on May 20, 1948

Immediate cause of death

Prematurity

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....

Means of injury

Injured at work?

23. SIGNATURE

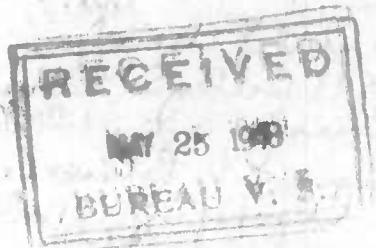
B. M. Schriver, M.D.

M. D. or other

Address

41 Green St

(Date signed) May 21, 1948



DR. R. WILLIAMS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04571

Reg. Dist. No. 4

CERTIFICATE OF DEATH

M
The correct age

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The causes of death clearly and legibly.

1. PLACE OF DEATH:
 County ALLEGANY
 City or town CUMBERLAND, MD.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 21 DAYS
 Hospital, institution, or street address where death occurred:
 MEMORIAL HOSPITAL
 How long in hospital or institution? 21 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State MARYLAND County ALLEGANY
 City or town CUMBERLAND, MD.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 826 GREENE STREET
 (If rural, give LOCATION)

3. (a) FULL NAME
 MR. FRANK W. SCHULTE
 4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced
 MALE WHITE MARRIED
 6. (b) Name of husband or wife MYRTLE DORIS HARPER
 7. Birth date of deceased (mo. day. yr.) AUGUST 1, 1883
 6. (c) If alive, give age 62 years
 8. AGE: Years Months Days If less than one day
 64 9 27 hrs. min.
 9. Birthplace ILLINOIS Richland
 (Town, county, and state)
 10. Usual occupation ENGINEERING DEPT. CELANESE
 11. Industry or business CELANESE CORPORATION
 12. Name FRANK SCHULTE
 MOTHER FATHER 13. Birthplace GERMANY
 14. Maiden name MARGARET Alfter
 15. Birthplace GERMANY
 16. Informant MEMORIAL HOSPITAL
 Address MEMORIAL AVENUE, CITY
 17. Burial Date thereof June 1, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Rose Hill Cem.
 Location Cumberland, Md.
 18. Funeral director H. Wayne George
 Address Cumberland, Md.

19. May 31, 1948 W.R. Faust, M.D.
 (Date rec'd by registrar) Registrar

3. (b) Social Security Number
 217-10-4569

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 28, 1948, at 12:27 A.M.

I CERTIFY that death occurred on the date above stated; that I attended deceased from June 15, 1947, to May 27, 1948, and that I last saw him alive on May 27, 1948.

Immediate cause of death:

Myocardial failure -
 Due to Hyperthyroidism
 Cardiac Vasculitis showed 10 yrs.

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

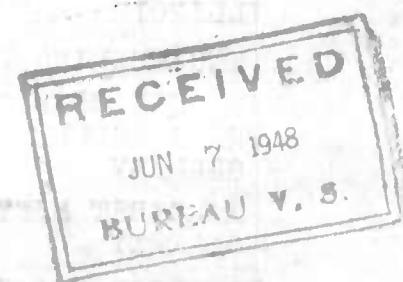
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W.R. Faust, M.D.
 Cumberland, Md. 5/28/48
 Address



Within corporate limits.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04572

93d

4

Reg. Dist. No.....

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County Allegany

City or town Cumberland, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

124 Oak St.

How long in hospital or institution?

3. (a) FULL NAME

George F. Sheetz

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Mary E.

7. Birth date of deceased (mo., day, yr.)

Oct. 26, 1892

6. (c) If alive, give age..... years

8. AGE:

Years	Months	Days	If less than one day
55	6	29	hrs. min.

9. Birthplace.....

Westernport, Md.
(Town, county, and state)

10. Usual occupation.....

Welder

11. Industry or business

B&O R.R.

MOTHER FATHER

12. Name.....

Charles S.

13. Birthplace

W.V.A.

14. Maiden name.....

Marie Peters

15. Birthplace

W.V.A.

16. Informant.....

George K. Sheetz

Address

124 Oak St.

17. Burial

(Burial, cremation, or removal. Which?) Date thereof May 28, 1948
(month) (day) (year)

Cemetery or crematory

Hill Crest Burial Park

Location

Cumberland, Md.

18. Funeral director.....

James F. Scarpelli

Address

Cumberland, Md.

May 26, 1948
(Date rec'd by registrar)John Stark, M.D.
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 124 Oak St.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

705-09-9783

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 25 1948 at 4:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 1942 to May 1948
and that I last saw him alive on Apr. 1, 1948

Immediate cause of death

Coronary Thrombosis

Due to

Chronic Myocarditis

DURATION

Sudden

6 yrs.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, pub'c place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Clay J. Durrett
Cumberland, Md. \$25/18.
M. D. or other
Address

Date signed

RECEIVED

JUN 2 1948

BUREAU V. S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct type is especially important. Physicians: please write the causes of death clearly and legibly.



Ely Briggs
ALM NO. G 116 JUL 6 1948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04573

181

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Allegany Hospital

How long in hospital or institution

3 day

3. (a) FULL NAME

Patricia May Shelley

3. (b) Social Security Number

None

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female white Single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

February 26, 1947

8. AGE:

Years

Months

Days

If less than one day

1

2

11

hrs.

min.

9. Birthplace

Cumberland, Allegany Co., Md.
(Town, county, and state)

10. Usual occupation

Child

11. Industry or business

Phillip Antonon Shelley Sr.

12. Name

Eckhart Mines, Md.

13. Birthplace

Hazel T. Jones

14. Maiden name

Cumberland, Md.

15. Birthplace

Philip D. Shelley Sr.

16. Informant

R. F. D. Cumberland, Md.

17. Burial

Date thereof May 10, 1948
(Burial, cremation, or removal. Which?)

Cemetery or crematory

St. Ambrose Catholic Cemetery

Location

Cresaptown, Md.

18. Funeral director

John J. Gaffey

Address

Cumberland, Md.

19. Date rec'd by registrar

May 10, 1948 W. L. Raatz, M.D.

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Allegany

City or town Potowmack Park
(If outside city or town limits, write RURAL and give nearest town)Street No. P. O. Box 5 Cumberland, Md.
(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 7 1948 at 9:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 4 1948 to May 7 1948

and that I last saw her alive on May 7 1948

Immediate cause of death

Second sign of death of all free burns, on forearms

Due to

Choke upper abdomen.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of 6/5/48

Where did injury occur? Cumberland, P. O. Box (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Home

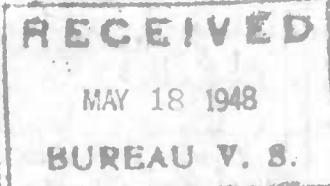
Means of injury Burned self with hot starch Injured at work?

23. SIGNATURE

Ely Briggs, M.D. M. D. or other

Ra Viel, M.D. Date signed 4/9/48

Address



I

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04574

45+

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

116 Blaup Avenue

How long in hospital or institution?

3. (a) FULL NAME

Anna L Smith

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Divorced

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

January 2, 1873

8. AGE: Years Months Days If less than one day

75 4 29 hrs. min.

9. Birthplace Bedford County Pa. (Town, county, and state)

10. Usual occupation Cook

11. Industry or business County Home at Bedford, Pa.

12. Name Joseph Cobler

13. Birthplace Bedford County, Pa.

14. Maiden name Mary Smith

15. Birthplace Bedford County, Pa.

16. Informant Claude B. Smith

Address 116 Blaup Ave.

17. Burial Date thereof June 3, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Wood Meth. Cem.

Location Rainsburg, Pa.

18. Funeral director James F. Scarpelli

Address Cumberland, Md.

19. June 2, 1948 W.R. Gratz, M.D.
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State _____ County _____

City or town _____ (If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION) ✓

2. (a) If veteran, name war.

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

2D. DATE OF DEATH

May 31 1948 at 3⁰⁰ P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 24 1948 to May 31 1948

and that I last saw her alive on May 31 1948

Immediate cause of death

Carcepsoma of the throat

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

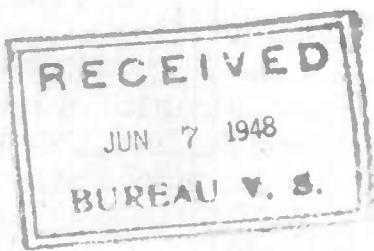
Injured at work?

23. SIGNATURE

J. Bailey Hunter, M.D. or other
Address 116 Blaup Ave, Cumberland, Md. Date signed

M.D. or other

Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04575
131a

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND, MARYLAND

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

MEMORIAL Hospital

How long in hospital or institution? 13 DAYS

3. (a) FULL NAME

D. RAY SMITH

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

MALE

WHITE

MARRIED

6.(b) Name of husband or wife ANNA E. NAUGLE

6.(c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.)

MARCH 5, 1894

8. AGE:

Years

Months

Days

It less than one day

9. Birthplace

PENNA

(town, county, and state)

10. Usual occupation

State road Commissioner

Bedford County, Penna

11. Industry or business

Bedford County, Penna

12. Name DAVID R. SMITH

13. Birthplace

OHIO

14. Maiden name

BARBARA SMITH

lived briefly

15. Birthplace

Bedford County, Penna

16. Informant

MEMORIAL HOSPITAL

Address

CUMBERLAND, MD.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof May 20, 1948

(month) (day) (year)

Cemetery or crematory

Cem. Cegy

Location

Penns, Penna

18. Funeral director

J. M. & G. G. G.

Address

Bedford Penna

19. May 17, 1948

John Frank, M.D.

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State PENNA

County BEDFORD

City or town BEDFORD

(If outside city or town limits, write RURAL and give nearest town)

Street No. R.F.D.#2

(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

NOON

20. DATE OF DEATH MAY 17

1948 at 12:00 M

21. I CERTIFY that death occurred on the date above stated. That I attended deceased from

May 4, 1948, to May 17, 1948,
and that I last saw him alive on May 17, 1948.

Immediate cause of death

Cardio vascular disease

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

none

Date of op. none

Autopsy results

none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

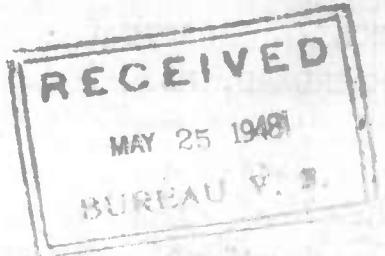
Means of injury

Injured at work?

23. SIGNATURE

W. J. Williams

Address Cumberland Date signed 5/17/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04576

940

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
 County ALLEGANY
 City or town CUMBERLAND
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 14 HRS 15 MI.
 Hospital, institution, or street address where death occurred:
 MEMORIAL HOSPITAL
 How long in hospital or institution? 14 HRS 15 MIN.

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State MARYLAND County ALLEGANY
 City or town CUMBERLAND
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 219 HUMBIRD ST
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

MRS VICTORIA TASKER

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

FEMALE WHITE WIDOW

6.(b) Name of husband or wife JOHN TASKER

7. Birth date of deceased (mo., day, yr.) DEC 6.(c) If alive, give age years
July 27, 18838. AGE: Years Months Days If less than one day
64 9 6 hrs. min.9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation HWFE

11. Industry or business

MOTHER FATHER 12. Name JAMES TASKER

13. Birthplace Oakland, Maryland

14. Maiden name ELEANOR SHROUT

15. Birthplace Oakland, Maryland

16. Informant Mrs. John Clark

Address 219 Humbird St. City

17. Burial Date thereof May 5-1948
(Burial, cremation, or removal. Which?)

Cemetery or crematory Oakland

Location Oakland md

18. Funeral director Envoy Bolden

Address Oakland md

May 3, 1948 W.R. Bratz, M.D.
(Date rec'd by registrar) Registrar

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 3 1948 at 4:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 1, 1948, to May 3, 1948
and that I last saw her alive on May 2, 1948

Immediate cause of death

Left Pulmonary Infarct 3 days

DURATION

Due to Coronary Sclerosis risks

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

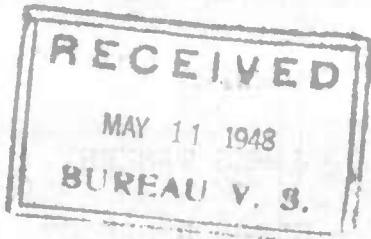
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

clayton burke
Cumberland 573148
M. D. or other
Date signed



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

97

04577

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

Allegany

County

Near Cumberland, Rural

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 Years

Hospital, Institution, or street address where death occurred:

Rt. 3, Bowman's Addn

How long in hospital or institution?

3. (a) FULL NAME

Charles E. VanPelt

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife

Mary (Sauers) Van Pelt

6.(c) If alive, give age years

7. Birth date of deceased (mo. day yr.)

November 26 1876

8. AGE: Years

71

Months

5

Days

21

It less than one day

hrs.

min.

9. Birthplace

Harrisonburg, Rockingham Co., Virginia

(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

11

MOTHER FATHER

12. Name

Henry VanPelt

13. Birthplace

Harrisonburg, Va.

14. Maiden name

Jane May

15. Birthplace

Harrisonburg, Va.

16. Informant

Kermit VanPelt

Address

Rt 3, Cumberland, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 5/19/48

(month) (day) (year)

Cemetery or crematory

Fountain Cemetery

Location

(Near) Keyser, W. Va.

18. Funeral director

William H. Kight

Address

Cumberland, Md.

19. Date rec'd by Registrar

May 19, 1948

W. D. Frazer, M.D.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

Allegany

City or town Near Cumberland, rural

(If outside city or town limits, write RURAL and give nearest town)

Street No. Rt. 3, Bowman's Addn

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 17

19 48

at 7:30

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

October 3 1947 to May 17 1948

and that I last saw him alive on May 10 1948

19 48

Immediate cause of death

generalized arteriosclerosis

DURATION

2 years

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

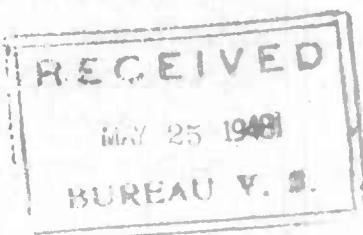
Injured at work?

23. SIGNATURE

M. D. or other

Address 59 Green St. Date signed 8-12-48

L. Brin's



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04578

108

CERTIFICATE OF DEATH

Reg. Dist. No.

9

1. PLACE OF DEATH:

County.....

City or town.....

Allegany

Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred

Meiers Hospital

How long in hospital or Institution? 2 weeks

3. (a) FULL NAME

Charles E. Walsh

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Widowed

6. (b) Name of husband or wife

Margaret Walsh

7. Birth date of deceased (mo., day, yr.)

August 26, 1872

5. (c) If alive, give age years

8. AGE:

Years

Month

Days

If less than one day

75

9

3

hrs.

min.

9. Birthplace

Frostburg, Allegany Md.

(Town, county, and state)

10. Usual occupation

Retired laborer

11. Industry or business

U.P.A.

MOTHER

FATHER

12. Name

James Walsh

13. Birthplace

Maryland

14. Maiden name

Ella Terrell

15. Birthplace

Maryland

16. Informant

Mrs. George Smith

Address

Cumberland Md.

Burial

Date thereof June 2 1948

Burial, cremation, or removal. Which?

(month) (day) (year)

Cemetery or crematory

St. Michael's Cemetery

Location

Frostburg, Md.

18. Funeral director

J. F. Durst

Address

Frostburg, Md.

19. (Date rec'd by registrar)

6 - 1

1948

Date signed

Registrar

Signature

M. D. or other

Address

134 E Main St. Frostburg

Date signed

5-30-48

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Maryland County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-30 1948 at 1 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

5-14 1948 to 5-29 1948

and that I last saw him alive on 5-29 1948

Immediate cause of death

Heart failure

Arteriosclerosis, anemia

Due to pneumonia, pneumococcic

6/20/48

Due to

Other conditions anemia, starvation

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Schoof Walferman M.D.

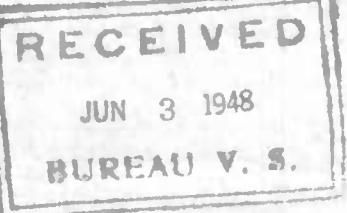
M. D. or other

Address

134 E Main St. Frostburg

Date signed

5-30-48



Within corporate limits

The cause of death
is especially important.

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15 M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The cause of death is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

13/a

04579

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGANYCity or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Memorial Hospital

How long in hospital or Institution? 14/DAYS

3. (a) FULL NAME

HERBERT WHEELER

4. Sex MALE 5. Color or race COLORED 6. (a) Single, married, widowed, or divorced SINGLE

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Unknown 6. (c) If alive, give age years 1890

8. AGE: Years Months Days If less than one day 58 hrs. min.

9. Birthplace WEST VIRGINIA
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business Farmwork

12. Name EDWARD WHEELER

13. Birthplace W. VA.

14. Maiden name MILLIE TEMPLE

15. Birthplace W. Va.

16. Informant Memorial Hospital
Address Cumberland, Maryland17. Burial Date thereof May 16, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Brownsburg Cem.
Location Brownsburg, W. Va.18. Funeral director H. Wayne George
Address Cumberland, Md.19. May 14, 1948 L. D. Tracy, M.D.
(Date rec'd by registrar) Registrar2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)State WEST VIRGINIA County POCOHONTAS
City or town CLOVERLICK, W. VA.(If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number None

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 13 1948, at 11:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 29 1948 to May 13 1948

and that I last saw him alive on May 13 1948.

Immediate cause of death Uremia

DURATION

Due to Chronic glomerular nephritis

Due to Hypertension

Other conditions Subarachnoid Hemorrhage

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, pub'l'c place (where?)

Means of injury

Injured at work?

23. SIGNATURE George M. Simon
M. D. or other

Address 7 Memorial Hospital Date signed May 13, 1948

